

THE LIVED EXPERIENCE OF OBTAINING
REQUIRED CHILDHOOD VACCINATIONS
FROM LATINO IMMIGRANTS' PERSPECTIVE

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Submitted to the faculty of the University Graduate School
in partial fulfillment of the requirements
for the degree
Doctor of Philosophy
in the School of Nursing,
Indiana University

December 2013

Accepted by the Faculty of Indiana University, in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ACKNOWLEDGEMENTS

I wish to thank the many people who have supported me and who have been instrumental in my journey through my doctoral education and helped me to reach a new understanding of how Latino families experience obtaining vaccinations for their children.

First I would like to thank the Hermeneutic Circle members who helped me explore the interviews that I conducted. Each of them provided me with insight and wisdom, and gifted me with their words. I give personal thanks to Dr. Marsha Ellett for the inspiration and confidence she instilled in me to pursue a doctorate of philosophy, and for her continued support as part of the Hermeneutic Circle.

I would like to thank the members of my dissertation committee. Their guidance and support through my dissertation has been greatly appreciated. Dr. Rose Mays graciously advised me on both advisory and dissertation committees, and Dr. Richard Ward helped me explore other cultures and views of medicine through an anthropologic perspective. Dr. Sharon Sims, I will never forget the words you spoke at my first meeting for graduate studies; ‘follow your dreams and the job will be waiting for you’. How fitting that at the end of my journey, you have become my committee chair! To Dr. Rebecca Sloan, all I can do is smile. You led me along the twisted wood path, through the dark forest of qualitative research, and now we have reached the clearing of understanding. Thank you!

To supporters outside the school of nursing I am indebted. Dr. Antonio Rosario, the pastor of an Hispanic church, whose discussion of the immigrant experience challenged me to change course from quantitative analysis and seek the immigrant

perspective through phenomenological research, and to his wife, Wanda, my best recruiter. To my dear sister, Dr. Judith Carlstrand, who tirelessly assisted in the translation of interviews and offered support through long months of writing. For my husband Gene, and daughters Natalie and Julie, who gave quiet support and tolerated my many years as a student, I am truly blessed. Finally, I salute the pioneer of nurses in our family, my mother Betty, whose lessons in organization while balancing career and raising six children provided me with a background for perseverance.

I dedicate this dissertation to my father, Paul Roman, who gave me the gift of dreaming. He was the first in his family to attend college, and personally drove me to Mexico, with a carload full of family and a camping trailer, so I could learn Spanish. Dad was a lifelong learner, and was passionate about education. He and Mom attended my graduation at the Masters level, and he would have been proud to see me hooded with the doctoral title. May you rest in peace.

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Vaccinations are an important step in preventing childhood illnesses and disease outbreaks in the community. Complete immunizations before school assure eligibility for enrollment and protect children against severe illness. The fact that foreign-born children of Latino immigrants face health disparities in receiving vaccinations is well documented. However, there is little information in the literature about the actual experience of immigrants facing the complexities of the health system, and through their eyes, which factors ultimately affect vaccination rates of immigrant Latino children.

The purpose of this study is to give voice to Latino immigrant families who have recently immigrated to the United States, in terms of the issues they encountered when engaging the health care system for vaccinations.

A convenience sample consisting of eleven Latino immigrant parents was obtained from information-rich participants of the immigrant Latino population, identified through clinics and churches. Each participant experienced seeking immunizations for their foreign born children during their first 5 years residing in the United States. Interpretative phenomenology guided the framing of the broad interview questions, probes, and data collection methods. Heideggerian hermeneutics guided the interpretation of the Latino parents' world with regard to seeking immunizations for their children from the picture they provided. By sharing their experiences, the immigrant parents provided a glimpse of their world with regard to childhood immunizations and the effects of individual, community and policy factors.

Subthemes that emerged under the umbrella of trust were health literacy, health disparities, finding a medical home, and preserving the family unit. The subthemes provided a framework to examine the immigrant journey from arrival to the United States, settling into a community, and projection into the family's future.

The broader goal of this study is to inform providers who review the study, and to improve outcomes for this vulnerable population.

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TABLE OF CONTENTS

Chapter One

Introduction.....	1
Purpose.....	5
Aims.....	5
Definition of Terms.....	5
Background and Significance	6
Contributions to Nursing Science	10

Chapter Two

Review of the Literature	11
Qualitative Research Methods	11
Phenomenology	11
The Philosophy of Heidegger	13
Literature Review	17
Acculturation studies	22
The Latino immigrant perspective of healthcare	26
Research findings in Latino parental viewpoint of vaccinations.....	34
Summary.....	39
Conclusions.....	44

Chapter Three

Methods.....	46
Participants.....	46
Procedures.....	47

Protection of Human Subjects	49
Measures	50
Data Analysis	50
Rigor	51
Summary	52
Chapter Four	
Data Analysis and Interpretation	53
The Metaphor	53
Tip of the Iceberg	55
Dispelling the Myth – health literacy	55
Trust	57
What Lies Beneath	62
Revealing the Concealed – health disparities	62
The Journey	67
Finding Their Way – the medical home	67
Preserving the family unit – looking toward the future	69
Review of Pertinent Literature	71
Trust as an issue in healthcare	71
Summary	73
Chapter Five	
Discussion and Implications	76
Data Analysis	76
Trust	76

Health literacy	77
Health disparities	78
Medical home	78
Preserving the family unit	79
Revisiting the Specific Aims	80
The Hermeneutic Process	80
Implications for Nursing Practice	81
Recommendations for Further Research	82
Limitations	83
Appendices:	
Appendix A.....	85
Appendix B.....	86
Appendix C.....	87
Appendix D.....	88
References.....	89
Curriculum Vitae	

CHAPTER ONE

Introduction

Vaccinations are an important step in preventing childhood illnesses and disease outbreaks in the community (HHS Fact Sheet, 2000). Complete immunization before school assures eligibility for enrollment and protects children against severe illness (Hodge & Gostin, 2002). In spite of this knowledge, there are children in the United States (US) who face health disparities in obtaining vaccinations (Smith, Stevenson, & Chu, 2006). The problem is so severe that the elimination of health disparities was targeted as one of the goals of Healthy People 2010, naming immunizations as a focus area (Healthy People 2010, 2000).

In 2002 the National Foundation for Infectious Disease (NFID) presented a report on the need to improve pediatric immunization rates for underserved populations. Barriers to immigrants were attributed to lack of insurance, inaccessible healthcare facilities, lack of understanding due to low level education, dependence on public transportation, poor language skills, and media scares about vaccinations (NFID, 2002). Another study by the Urban Institute looked at the 2002 National Survey of American Families and reported poor health as a result of disparities and a lack of an identified health care provider, placing blame on the decline in Medicaid and State Children's Health Insurance Program (SCHIP) coverage (Capps, Fix, Ost, Reardon-Anderson, & Passel, 2005).

The 2005 Healthy People Midterm Report indicated that some progress has been made towards closing the gap in disparities in the immunization focus area. Using the Latino population as a gauge, immunizations for Latinos improved from 73% completion

rate in 2000 to 82% in 2006, but this was still behind the majority or white population whose rate increased from 80% to 84% in 2000. Vaccinations for persons at poverty level were at 78% in 2006 (Child Trends Data Bank, 2006); this was projected to be still higher than rates for immigrant children. Examination of the Latino immigrant perspective helps shed light on why these statistics are lower than in the mainstream population.

The fact that foreign-born children of Latino immigrants face health disparities in receiving vaccination is well documented (Kandula, Kersey, & Lurie, 2004). The Latino is predicted to face disparities at both the community and individual levels (Child Trends Data Bank, 2006; NFID, 2002). At the community level due to immigration laws, the Latino is denied insurance coverage except for emergencies, a factor that greatly affects the ability to choose private healthcare providers (Juang, Yu, & Ledsky, 2006). Community factors such as the denial of Medicaid and SCHIP programs to foreign-born children of legal immigrants for the first 5 years of residency are well documented (Kaiser Commission, 2006). However, there is very little information in the literature about the actual experience of immigrants facing the complexities of the health system, and through their eyes, what factors ultimately affect vaccination rates in immigrant Latino children (Capps et al., 2005).

At the individual level, the lived experience of immigrants, as well as factors that preclude the acquisition of vaccinations, are poorly understood. Understanding these experiences are important because while some parents are able to overcome obstacles and obtain vaccinations for their children, others do not, thus perpetuating the health disparity. Exploring the themes from individual immigrant experiences provides avenues to better understand issues for those immigrants who fail to obtain vaccinations for their

children. The ultimate goal is to protect children and the community at large against severe disease, to assure the required readiness for school enrollment, and to reduce health disparities in the Latino population.

I was only ten years old when I first accompanied my mother, a nurse for the local public health office, to a migrant community in our small town. It was there I became aware of the human condition of this marginal population, and its lack of access to standard health care and living quarters. I was equally impressed that the migrant children tended crops rather than attending school. Years later I would remember that experience as a comparison to how modern immigrant families live.

During high school I was fortunate to be chosen as a foreign exchange student to Mexico, where I was immersed in the culture and language by living with families. I became sensitive to some of the nuances in Hispanic health beliefs, and learned how Hispanics approached health in general. In college I studied both biology and Spanish, but later returned to school for a nursing degree, which became the focus of my career. My personal experience as an immigrant occurred when I moved overseas to Sri Lanka for three years. During that time my oldest daughter was born, and together we experienced obtaining her first vaccinations. Fortunately I had access to the same immunizations given in the US, and Natalie's records were accepted without question upon our return, unlike some of the participants in this study.

Old dreams of combining a nursing career with my love for the Hispanic language and culture started forming into a reality in spring of 2005 when I was included in the IUPUI medical mission to Calnali, Mexico. Students from nursing, medical school and dentistry joined forces with students from the University of Hidalgo to serve the poor in

the Mexican mountain communities. I was involved in a research project to examine the local views of health care needs. Meanwhile, in my own backyard, the number of Hispanic immigrants coming to Midwest US had recently blossomed, and I was aware of a tremendous need for culturally sensitive health providers to assist in the future plight of these individuals. I felt most comfortable studying vaccinations for small children due to my experience as a nurse and a mother.

I entered into the PhD program in nursing, intending to formulate a questionnaire to assess vaccination needs in the Hispanic immigrant community. When I enrolled in the obligatory qualitative research course, I interviewed a member of the local Hispanic community, and my entire format changed when I realized the inadequacy of my questionnaire. I decided to shift gears to qualitative work, and joined the Hermeneutic Circle. This is a group comprised of qualitative researchers focused on Heideggerian Hermeneutics, and graduate students pursuing studies through the philosophy of Martin Heidegger. The group met on a regular basis to review de-identified transcripts from student research in an effort to lend interpretations and reduce researcher bias. I was deeply immersed in my data, and this process allowed me the gifts of less biased interpretations, and helped clarify my thoughts.

Having been a stranger in a strange land laid some of the groundwork for my sensitivity to the immigrant perspective. I strongly believe the voices of my participants were heard because the research was conducted in their native tongue. My research was conducted in Spanish, unlike some of the literature I reviewed, and created a stronger basis for trust and understanding.

Purpose

The purpose of this study is to give voice to Latino immigrant families who have recently immigrated to the United States, in terms of the issues they may have encountered when engaging the health care system. The specific aim of this study is to understand their experiences procuring required vaccinations for their young children. Interpretative phenomenology guides this study.

Aims

1. Describe the lived experience of recent Latino immigrants in obtaining vaccinations for their foreign-born children.

Definition of Terms

There are several terms that need defining when one is discussing any type of research involving families and their experiences. The following conceptual definitions were used for this study:

Health disparity. According to National Institute of Health, health disparity is defined as “differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States” (NIH, 2004).

Vulnerable population. The term vulnerable population pertains to susceptibility. As related to health the term refers to a group at greater risk for developing health problems due to marginalization or reduced access to care. Immigrants are considered a vulnerable population (Aday, 2001).

Latino. “A heterogeneous population comprised of numerous ethnicities that are related, but distinct” (Bosworth & Horner, 2009). Specific to this study, a person of Latin-American origin living in the United States.

Trust. “Assured reliance on the character, ability, strength or truth of someone or something. One in which confidence is placed. Dependence on something future or contingent: hope. A charge or duty imposed in faith or confidence or as a condition of some relationship” (Merriam-Webster, 2009).

The lived experience. For the purposes of this study, the lived experience was defined as the way a person experiences and understands his/her world and what that experience means to him/her. The experience must be captured in language to be truly shared.

Interpretive Phenomenology. For the purposes of this study, interpretive phenomenology was the methodology used to interpret the phenomena of the lived experience by both allowing the phenomena to speak for itself and by interpreting stories of persons experiencing the phenomena.

Background and Significance

Health disparities were recognized in the US and appeared in the literature as early as 1906, in an article by DuBois entitled *The Health and Physique of the Negro American* (American Journal of Public Health [AJPH], 2003). In his article, DuBois proposed that health disparities between races in the US were due to poorer socioeconomic and sanitary conditions as opposed to racial differences. Other key reports furthered the discussion of health disparities. For example, Lalonde (1981) introduced a new model for health care that looked at health determinants such as human biology, environment, lifestyle and health care rather than the traditional science-based viewpoint.

In 1980, Black reported on inequalities in health care in the United Kingdom and stated that many inequalities were based on socioeconomic disparities. In January 1984, the secretary of the US Department of Health and Human Services (DHHS) established the Task Force on Black and Minority Health. The Task Force issued a report of its findings in October 1985, known as the Heckler Report. The report contained details of a study of health disparities between racial/ethnic groups of the US and compared death rates of minorities to nonminority populations analyzing 40 disease categories. Recommendations were made for interventions and further study to reduce disparities in health between minorities and nonminority groups (Center for Disease Control [CDC], 1986).

In 1988 the Office of Minority Health was established to further address disparities (CDC, 2009), and was expanded to become the Office of Minority Health and Health Disparities (OMHD) in 2005. In 2008 the OMHD became housed within the Office of the Chief of Public Health Practices in order to better facilitate the reduction of health disparities for US vulnerable populations (CDC, 2009).

As minority groups and vulnerable subpopulations continued to comprise a greater portion of the overall population, the need to improve minority health became a predominant national focus. Since the mid 1970s the US government sought to study and set forth agendas to meet the needs of national health concerns. The US Department of Health and Human Services organized massive studies in order to promote health. A national project was initiated in 2000: the Healthy People 2010 program. In the program, there were two overarching goals: (a) to increase quality and years of healthy life and (b) to eliminate health disparities in the nation. In order to eliminate health disparities, Healthy People 2010 identified leading health indicators that were to reflect the major

health problems. The vaccination of children was named among the leading health indications. In 1998 a reported 70% of children had completed recommended vaccinations; the projected Healthy People 2010 goal was 90%. While the immigrant population is not listed separately in the program, studies show their vaccination rate to be estimated at a dismal 45% in comparison to established Latinos (Kandula et al., 2004).

Today there are vulnerable subpopulations in the United States whose health is most susceptible to health disparities, and these groups share the commonalities of racial/ethnic minorities, lower socioeconomic status (SES), children and adolescents, the elderly, homelessness and chronic health conditions (Shi & Stevens, 2005). There are also well defined determinants of health that influence health and outcomes: social determinants, physical environment, behavior and lifestyle, genetics and medical care. The combination of vulnerability and social determinants of health are factors that place a foreign-born immigrant child into a high risk profile (Shi & Stevens, 2005).

Immigrants often are considered vulnerable populations due to their transition in adjusting to the receiving country's healthcare structures, as well as economic, social and cultural differences (deChesnay & Anderson, 2008). In the US immigrants may fall into policy gaps that affect access to insurance and health care. Immigrants whose first language is not English may encounter language barriers and may not understand how to maneuver within the system or instructions from providers. Socioeconomic status may also affect ability to pay or to obtain adequate insurance coverage (Shi & Stevens, 2005).

Recent trends in immigration have changed due to the economic climate. Rather than seeking traditional locations such as California, Texas or Florida, recent Latino immigrants have settled into small towns or rural areas of the Midwest. Although the

receiving communities may have seen the occasional migrant family, they were ill prepared for the massive influx of immigrants in areas of language services, schools and health (McConnell, 2008). According to research on immigration trends of Mexicans to the US from 1980 to 2000, immigrants from Mexico dispersed into 47 new settlement states (Light & von Scheven, 2008). Traditional destinations once attracted immigrants because of available social networks with established Latino communities that could decrease the costs of relocation both socially and financially (McConnell, 2008). However, in 1986 the Immigration Reform and Control Act (IRCA) served to divert immigrants from traditional locations because of its negative effect on wages and working conditions (Light & vonScheven, 2008). As a consequence, immigrants began to feel pushed toward new settlements. McConnell cites data from the Mexican Migration Project (MM107) that studied migration patterns from 107 Mexican communities and categorized destinations as large or small traditional urban, nontraditional urban, (including Indianapolis and Fort Wayne, Indiana) and rural areas.

Another rationale for migratory habits was the human capital theory, according to which the individual chose a destination based on education and skills. Thus, migrants with limited English proficiency skills would be more likely to choose a location with larger Spanish speaking populations (Bauer, Epstein, & Gang, 2005). However this was not the case; poorly educated Latinos were more likely to be attracted to job opportunities in the low skill sector, irrespective of the community (Lichter & Johnson, 2009).

Currently the first generation immigrants are typically less educated, have poor English and low job skills. A study by the Urban Institute shows that new trends in immigration have doubled the number of immigrant children between 1900 and 2006 and

that children of immigrants are 22% more likely to be poor (Fortuny, Capps, Simms, & Chaudry, 2009). More than half of the current children of immigrants are Latino, many of whom are linguistically isolated, especially in the new growth states (Fortuny et al.). Families migrating into areas without existing Latino social networks encounter barriers to incorporating into the destination site. The complicated, unfamiliar, and prohibitive healthcare system along with language barriers, low education and low economic status all serve as barriers that perpetuate their status as a vulnerable population.

Contributions to Nursing Science

This study broadens the science of nursing by providing insight into the significant lived experiences of immigrants as they face the US healthcare system. It brings into focus issues through the lens of first generation immigrant parents who are attempting to obtain health care for their children, and enlightens providers on problem areas. The gap in knowledge about their experiences is addressed using qualitative methods of research.

CHAPTER TWO

Review of the Literature

To begin the qualitative research process, a preliminary literature review is conducted in order to ascertain available information related to the research topic. Gaps in the literature act as a guide when formulating research questions and probes to explore the phenomenon in question. In Chapter Two a brief discussion of phenomenology is presented, followed by the key concepts of Martin Heidegger's philosophy, in order to lay a background for data interpretation. The subsequent literature review explores research pertinent to the Hispanic immigrant's perspective of healthcare and vaccinations, as well as acculturation into the United States society. The chapter ends with conclusions that support the need for this study.

Qualitative Research Methods

The premise of a phenomenological qualitative study is to understand the "human experience as it is lived" (Polit, 2004, p.249); in this instance, to capture truths that contribute to nursing knowledge. Narratives about first-hand experience are collected and analyzed to search for common themes, but outliers are also carefully considered, more so than in quantitative studies. Qualitative methods are considered a holistic approach to research, as compare with traditional reductionist methods, thereby encompassing the entire lived experience.

Phenomenology

Even within the realms of qualitative research, theories have been developed that can limit the researcher to a set method. For example, ethnography works within the confines of a set cultural perspective to gain understanding within that culture (Munhall,

2007). Another example, in grounded theory, the goal is the development of an explanatory theory for human behavior (Munhall, 2007). In contrast, phenomenology comes without constraints or presumptions; it is atheoretical. This freedom allows the researcher to follow where the narrative leads, and to fully explore the human experience. Through use of the qualitative phenomenon approach, to the question of the Hispanic immigrant experience, one is able to reach beyond Healthy People statistics, Orem's theory of Self-Care or ethnographic methodology, and fully explore the immigrant's experience from his own perspective.

Phenomenology allows the researcher to dwell in the data as received, to find the essence of the phenomena. Once essences are defined, the work of interpretation begins. For this study, the philosophy of Martin Heidegger was used to assist in interpretation of findings. Heideggerian hermeneutics is a scholarly tool used to discover themes and exemplars that provided insight into the Hispanic immigrant experience.

It is important to note that there are two basic types of phenomenology: descriptive and interpretive (also known as hermeneutics). Descriptive phenomenology was developed in the 1900's by German professor Edmund Husserl. Husserl emphasized the importance of describing the human experience. His student, Martin Heidegger, developed interpretive phenomenology that went beyond describing the human experience. Interpretive phenomenology sought to reveal "hidden aspects in need of evocation and interpretation" (Guignon, 2007, p.101).

Both descriptive and interpretive phenomenological studies use data collected from conversations between researcher and participant about the latter's lived experience. The researcher uses general probes related to the inquiry, but the conversations are not

structured, so that the participant is free to express his thoughts. From there, the descriptive method takes the path towards understanding and describing the phenomenon. In descriptive phenomenology the researcher suspends or brackets explanations in order to avoid preconceived ideas about the phenomenon. In contrast, the interpretive or “hermeneutics presupposes prior understanding on the researcher’s part” (Polit, 2004, p. 254) and focuses on the interpretation of the lived experience. In spite of having some preconceived ideas, the interpretive researcher may still be in store for surprises. It is in revealing the concealed that enriches the findings of interpretive phenomenology studies.

In his doctoral dissertation, *Being and Time*, Heidegger presented an extensive discussion on the interpretation and understanding of the human experience. In the following section I have explained the basics of Heideggerian philosophy, which I later used to interpret research findings in Chapter Four.

The Philosophy of Heidegger

Martin Heidegger was a 20th century German philosopher who developed hermeneutic philosophy as an approach to explain being human. A student of Edmund Husserl, Heidegger disagreed with Husserl’s transcendental phenomenology and broke away from the traditional Descartes “I think, therefore I am” mantra. According to Heidegger, ontology provided a better explanation of human thought, “asking about the nature of this understanding of being that we do not know” (Dreyfus, 1991, p. 3). In ontology the human lived experience cannot be separated from context. Human thoughts are connected to our past, present and future thoughts in a perpetual circle of interpretation.

In order to explain his philosophy, Heidegger used several key terms that will now be presented. The first central concept is that of Dasein, translated into English as “being-there” (Langenscheidt, 1993, p.79), more loosely defined as human existence. Using Heidegger’s ontological approach, Dasein explains the experience of what it is to be a person at a certain moment in time, placed within the context of his known world, or Being-in-the-World. Each human being has an understanding of his world, and that which is familiar or ready-at-hand. The complexities of Being-in-the-World help to define the individual’s experiences including location, language, historical time and culture. All these contribute to things that have significance and meaning, both physical objects and nonphysical entities, and how to behave or comport in everyday situations.

“It is from choosing to own one’s Dasein that the individual defines his authentic self; to be true to one’s own beliefs, and behaving thus, one can be authentic. To disown or stray from one’s normal comportment is to be inauthentic” (Dreyfus, 1991, p. 27). For example, a Latino immigrant mother would ordinarily take her ill child to a doctor (authentic behavior) but finds she seeks alternatives when denied this opportunity due to a lack of insurance, thereby forcing inauthentic behavior.

Even though a human exists within his world, he does not always act in a conscious manner, because behaviors become automatic. Compare this idea to driving a car. The act of driving eventually becomes so engrained that the unconscious mind takes over, and one is not aware of the mechanics of driving until an interruption occurs. For example, a functioning window wiper is not noticed until it malfunctions, then the driver becomes acutely aware of its function and takes deliberate action. In Heideggerian terms, this is known as Breakdown. Breakdown can be a malfunction, a temporary state in that

one becomes conscious of a problem and acts deliberately to overcome it, or total breakdown can cause a permanent interruption in daily life.

Heidegger says there are three types of breakdown: malfunction, temporary, and total breakdown. Imagine an immigrant taking his child for health care and in the process discovers he cannot understand the health care provider. This would initially cause a *malfunction*, or a conspicuous breakdown, to which the immigrant will most likely cope by withdrawing. He may simply nod “yes” to questions in order to prevent embarrassment, or avoid the provider in the future to prevent incidents. In *temporary* breakdown, one becomes aware of the problem and begins to *act deliberately* during future activity. In temporary breakdown, our sample immigrant becomes aware of the communication problem and asks for an interpreter to rectify the problem. In *total* breakdown work is permanently interrupted. Coping actions include finding casual properties (Dreyfus, 1991, p. 79) or seeking fault of the health care facility. In this scenario, the immigrant might seek some form of retaliation for perceived poor medical care.

Another important concept when using Heideggerian philosophy for data interpretation is that of “thrownness”. A person-in-the-world understands his everydayness, and how to behave in a variety of situations according to the context of his world. However, when one is thrown into unfamiliar surroundings, such as an immigrant who moves to a new country, and no longer has control over his circumstances. Initially the immigrant must learn the new world norms and might wander aimlessly “along the twisted wood path” until he reaches a clearing of understanding. It is in the clearing that

the concealed becomes visible, and his experiences provide new insight and understanding of his new surroundings.

One of the main goals in qualitative phenomenology is to bring to a conscious level what is hidden in the subconscious, to reveal the concealed. Through the interview process and allowance for open-ended expression, research participants reveal thoughts that are normal so ready-at-hand as to be obscured by everydayness. For example, in the Latino world the concept of trust is so engrained and embedded that it subconsciously flavors perceptions and reactions to everyday circumstances. Therefore, when the immigrant experiences a health care provider who is efficient but lacks a warm and personable character, his tendency is to distrust the provider even if the health outcome is favorable. Qualitative phenomenology helps to reveal this underlying way of thinking of the Latino immigrant viewpoint. It is in understanding the importance of establishing trust with the Latino patient that health care providers can become aware that efficiency alone does not keep the patient coming back to the clinic.

Finally, Heidegger addresses the concept of “the stay of mortals on the earth” (Heidegger, 1977, p. 351). This is a complex concept in which Heidegger describes a fourfold relationship between earth, sky, mortals and divinities safeguarding “each thing in its essence”, (Heidegger, 1977, p. 351), providing a peaceful coexistence. In his writings, Heidegger defines the essence, or balance, of the relationship as dwelling or safeguarding. Since only mortals can die, they must carefully dwell or preserve the capacity to live within the fourfold. The best relationship with the earth is not to exploit or wear it out. “Saving the earth does not master the earth and does not subjugate it” (Heidegger, 1977, p. 352). The sky is left undisturbed so that mortals adjust their own

activities according to day/night and seasonal changes; “they do not turn night into day nor day into a harassed unrest” (Heidegger, 1077, p. 352). The mortal relationship with divinities is to not create false idols, but to await the divinities. In viewing these concepts from an analytical stance, the earth represents knowledge, the sky is the unknown, humans are mortals because they can die, and divinities are the gods. In order to preserve the essence of the relationship, each of the fourfold must be kept safe (Heidegger, 1977). The analysis in my research places the mortals as representative of immigrants due to their vulnerability, the divinities are health care providers due to their perceived power in the relationship, the earth represents knowledge, and the sky remains the unknown. The essence of this fourfold relationship is discussed in Chapter Four.

Literature Review

In reviewing the literature it is important to consider the immigrant perspective of risks and barriers to healthcare, as well as cultural practices including decision-making processes. Studies directly related to the Latino immigrant perspective were limited; therefore the scope was expanded to include related topics in order to gain a more complete understanding. The expanded search revealed three main categories of research: acculturation studies in established Latino communities, quantitative and qualitative studies that focus on the Latino perspective of healthcare in general, and then specifically, the Latino parental view of immunizations.

Acculturation is defined by Berry (1997) as a phenomenon that occurs when two differing cultures come into continuous contact with subsequent changes to one or both of the groups. According to Lara, Gamboa, Kahramanian, Morales, and Bautista (2005), a bi-dimensional model of acculturation proposes degrees of cultural maintenance whereby

an individual adheres to his original culture. The subcategories of bi-dimensional acculturation are helpful to know when reviewing research data: assimilation, or the complete acquisition of new culture, separation or avoidance of the new culture, integration defined as valuing both cultures, and marginalization or exclusion by both cultures (Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005). Some scales used to measure levels of acculturation have used length of exposure to the new culture in terms of time or generation, nativity, education and responses, while other scales have used culturally specific questions (Lara et al., 2005). In developing a research agenda for immigrants, it is prudent to review articles on the acculturation studies of the group of interest (Mendoza, 2009).

Anthropologists have done extensive research on the cultural particulars of Latinos with regard to health beliefs and practices. One such study was during the mid-1950's when a University of Berkeley graduate student conducted a complete sociocultural analysis of Mexican-Americans living in the barrio called *Sal si Puedes*, ("leave if you can") near San Jose, California. The extensive research included a census, multiple in-depth interviews with key informants, and observations of the community with regard to health practices. The study uncovered a rich array of traditional folk medicine including ideas on disease causation and folk remedies, along with perceptions of medical, hospital and public health services (Clark, 1970). Four main health beliefs serve as a backdrop to understanding Latino perceptions of health. "Hot and cold" theory, a dominant belief throughout Latino America is derived from the Hippocratic theory of four humours (phlegm, blood, black and yellow bile) where some are thought to be innately cold (Clark, 1970). This theory, brought to Latin America through Spanish

explorers in the sixteenth century, places hot and cold values on food items thought to affect illness and death. A second folk theory is that internal organs may become dislocated, for example in *mollera caida*, or fallen fontanel. The depression in an infant's hard palate is thought to cause severe diarrhea and vomiting (Clark, 1970). The third concept, magic, plays a role in Latino folk health; *mal ojo* or "evil eye" occurs when sickness befalls a child after someone looks at him with ill intent. According to folk remedies, *mal ojo* is curable by a *curandera*, or medicine woman, who uses an egg to exorcise evil. Another magical concept is that bad air or *mal aire* can also cause a victim to fall ill. The fourth source for disease in Latin folk medicine has emotional origins; the most common emotional state is *susto*, or fright, and is believed to be caused by supernatural forces and evil humans (Rubel, O'Neil, & Collado-Ardon, 1984). The individual experiences a frightening experience that subsequently affects his health in some manner, sometimes leading to incapacitation or even death (Rubel et al., 1984).

Ethnographers discovered that Latinos have a variety of healthcare resources in their native countries; providers range from western doctors to *curanderos* and shamans, and most recently there has been a trend towards natural or homeopathic medicine. These sources of care have been found to be prevalent across Mexico, Central and South America. *Curanderos* are also known as medicine men, in folk terms. They use herbs, potions and folk remedies to cure illness. Shamans, on the other hands, may use healing rituals and spiritual cures in the process of diagnosis and cure of illness (Brown, 1998). Spiritualistic medicine is common in some parts of Latin America, especially Mexico (Morley & Wallis, 1978). Spiritualists use the belief in God as a basis for curing illness, and a cure depends upon whether the patient has strong faith. The spiritual healer acts as

a medium and uses imagery such as the “visualization of body ailments and their magical treatment” (Morley & Wallis, 1978, p. 37) to treat symptoms. Homeopathic medicine is the use of a naturalistic approach using herbs and botanical treatments in place of Western pharmaceuticals. The concept, developed in early 19th century Germany (Whiteford, 1999), is to use small amounts of substances that can induce the same symptoms the patient exhibits to arouse a natural healing response. Homeopathy is often used in chronic conditions and is popular in Latin America, especially Mexico. Women tend to use homeopathy more often than men, in an effort to have control over their health (Whiteford, 1999).

Other important aspects of Latino health beliefs are the expectations of health providers and cultural expectations in general. The perception of *personalismo*, or personal touch, is an important factor in the formation of *confianza*, or trust, between the Latino immigrant and healthcare provider. Decision-making in the Latino cultural is traditionally done by the family rather than the individual (Galanti, 2003), that reflects the concept of family of *familismo*, although parents will make decisions for their children. Another important expectation is *respeto*, the respect for elders and those individuals with experience (LaViest, 2005). Whether these beliefs affect the Latino perspective of healthcare within the United States system is of interest in this review.

Since the initial ethnographic studies, many changes have occurred in the United States where Latino immigrants are concerned. Trends of immigration have taken newcomers far from the familiarity of well-established Latino communities into unchartered destinations such as the rural Midwest. Today’s immigrants may hold onto traditional beliefs and practices, or they may prefer to assimilate rapidly into mainstream

healthcare. Either way, barriers arise, from the lack of social networks in new destinations, to the lack of financial advantages such as health insurance. A review of the literature reveals what is known about the problems and issues today's immigrants' voices from their own perspective.

Sturm, Mays and Zimet (2005) have delineated how parental concerns affect the acquisition of immunizations for their children. Although the role of immunization in preventive medicine is to protect children against disease, parents may decide not to immunize due to a variety of influences. Cultural attitudes and beliefs about immunization including media coverage can negatively or positively affect parental decisions. Cognitive factors involved with decision making are related to parental knowledge about disease process, the immunizations themselves, and the perception of susceptibility to health threats. Provider recommendations and access to care are other factors that influence the acquisition of immunizations. Legal mandates and professional organizations also play a role in parental perceptions of the safety and importance of immunizations. Prevalence of vaccine preventable diseases in the local area can influence parental decisions based on the familiarity with the disease and the level of concern to prevention through immunization (Sturm, Mays & Zimet, 2005). Although not limited to Latino parents, the information from the Sturm study provides a framework for considering the parental perspective.

According to Sturm (2005), during the 1950s the fear of contracting polio was a real threat to the community, whereas in today's industrial countries polio is no longer seen as a threat. However, as more parents opt out of vaccinating their children, herd immunity, or the chance of being protected against a disease because a significant

number of persons in the community are vaccinated, decreases. In Indiana there have been outbreaks of the measles as recent as 2012 that caused mandated vaccinations for children and teachers in specified districts (PBS, 2012). Due to outbreaks of pertussis the Center for Disease Control now recommends that adolescents and adults received an additional pertussis booster with their next tetanus booster (CDC, 2013).

The literature review helped determine availability of studies on Latino parental attitudes and beliefs about immunizations. The initial comprehensive literature review started at the beginning with migration and acculturation, followed by review of the Hispanic immigrant perspective of healthcare, and more specifically, the Hispanic parental viewpoint of vaccination, helped to formulate the current research question.

Acculturation studies:

“Migration, even under the best of conditions, involves a series of events that can be highly traumatizing and that can place migrants at risk. The process involves uprooting, being separated from family and traditional values, and being placed in new social and cultural situations where job and legal security may be minimal. For many migrants, social integration is rarely easy and for some impossible.”
(Carballo & Nerukar, 2001, p. 557)

Early studies on health disparities for the Latino immigrant population focused on aspects of acculturation and access to care. The Hispanic Health and Nutrition Examination Survey conducted from 1982 to 1984 by the National Center for Health Statistics (NCHS) sampled the Latino populations in the Southwest, Texas, Colorado, Florida and New York where immigrants had established communities (Solis, Marks, Garcia, & Shelton, 1990). Highlights that were discussed included access to care, utilization and preventive behavior. Other studies such as the Acculturation Rating Scale for Mexican Americans (ARSMA) done in the 1980s looked at language, ethnic

interaction, cultural heritage and general proximity (Cuellar, 1980). The early studies found that outreach to the Hispanic population in Spanish or through bilingual providers was beneficial, lack of insurance was a barrier to health care, and many Hispanic patients did not have a regular health care provider.

More recent studies have been directed toward the acculturation process in established Latino communities where comparisons were made between recent and long-term residents with regard to healthcare. Durden (2007) conducted a cross-sectional survey to sample and interview, households with children age 0-17, sample size of 35,260 participants. The study drew data from the National Health Interview Survey 1999 to 2001, and analysis was done by multinomial logistic regression. His study examined regular source of healthcare for children, focusing on the immigration status of the mother (nativity, duration in US, citizenship status). Durden (2007) found Latinos more likely to report emergency room over private doctor as usual source of healthcare. He also found that nativity, duration and citizenship status explained much of the differentials when compared with non-Hispanic whites. The study showed that as length of stay in the US increased, acculturation also increased in terms of seeking healthcare from private doctors. This finding helped to validate needs of Latino immigrants in terms of entry into healthcare. However, the survey was conducted in English, increasing possible bias. It also focused on nativity of the mother, not of the children, which did not answer research questions pertaining to foreign-born children. Data provided general information about healthcare disparities, but did not capture the immigrant viewpoint. In this respect, a qualitative study performed by a bilingual researcher is better positioned to those questions than is Durden's quantitative design.

Weathers, Novak, Sastry, & Norton (2008) examined the effect of parental nativity on child health and access to health care and investigated health as perceived by subjects (2008). The study used data from 2002 National Survey of America's Families, randomly sampled households with up to two children (N=34,442 children). Analysis was done by multivariate logistic regression. The conceptual approach of "Behavioral Model for Vulnerable Populations" was used as a basis to select control variables. Findings showed that children with foreign-born parents were less likely to have a usual health care site, and that mixed-nativity parents were associated with perceived improved health for children. Foreign-born parents perceived worse child health, but the child's citizenship was not a significant factor. However, the lack of a usual health care site was statistically significant for non-citizen children when compared to US citizens. This study included information on both child and parental nativity, unlike the Durden (2007) study that only looked at maternal nativity. The inclusion of children's nativity provided a basis to discuss the need for healthcare policy reform for foreign-born immigrant children. Another positive item was that the survey was available in Spanish for participants. Statistics specific to Latino participants were well delineated, so that one could draw conclusions regarding ethnicity. Although information was available specific to the Latino immigrants, the data did not differentiate documentation status for non-citizens. In fact, the authors stated that findings on the perception of child's health were not consistent. They also commented that a study on factors influencing parental perceptions would be needed to further investigate this concept (Weathers et al., 2008), further supporting the need for a qualitative study.

A different angle using an acculturation focus was found in a study performed in 2007 by Uretsky and Mathiesen, who examined the effect of immigrant status and duration in the United States (US) on health status, focusing on California's foreign-born populations. In this study, data from 2003 California Health Interview Survey was used. There were 42,044 respondents, of whom 10,420 subjects were foreign-born; all were interviewed by telephone. Analysis was done by binomial logistic regression, that compared foreign-born to US born cohorts, and a second model used only foreign-born population to allow for inner and inter-group comparisons. Findings showed that a decrease in self-assessed health was associated with increased duration in the United States as compared with US-born population. Initially the foreign-born showed a health advantage named the 'immigrant health paradox', and consisting of lower rates of cancer, cardiovascular disease and disability rates. The authors attribute this paradox to migrant selectivity and protective factors; the advantage declined with number of years spent in the United States. The second model comparing foreign-born population did not show significance for Latino health over other foreign-born populations living in California. Interviews were available in Spanish, which helped to increase understanding of the questions. Findings supported the need for policy reform: to increase access to healthcare during the first five years of residency in an effort to reduce the decline in health experienced by immigrants. Subjects were 18 years and over, and therefore the study did not address the research aim of the current study regarding immigrant children. Although Uretsky and Mathison's study provided a general account of immigrant health, it did not give insight into specific issues of the Latino population. The authors recommended research on children as important to the future of healthcare. Although the authors

maintained that findings were generalizable to California (Uretsky & Mathiesen, 2007), there may be differences across the United States, especially in areas where Latino communities are not well established, for example, in Midwestern states.

These acculturation studies helped to start a foundation for research of the Latino immigrant population, but none adequately explored the Latino perspective. Therefore, a further review of the literature for studies specifically addressing the Latino immigrant perspective of health care in the United States was conducted.

The Latino immigrant perspective of healthcare:

Nation-wide studies have addressed barriers to health care in the Latino population, but few have examined the perspective as seen by Latino immigrants. However, in 2007, a joint Pew Hispanic Centers and Robert Wood Johnson Foundation Hispanic Healthcare Survey [PEW/RWJF] (Livingston, Minushkin, & Cohn, 2008) was conducted to collect information about access to care, and to review Latino sources of information and knowledge about disease. From that study, a consortium of researchers grouped several articles addressing disparities in Latino healthcare to provide a special supplement to the Journal of General Internal Medicine (JGIM). The purpose of the supplement was to recognize disparity issues from the Latino perspective, and to advance strategies to reduce gaps through healthcare reform initiatives (Rodriguez & Vega, 2009). The first topics addressed were perceived quality of care, preventive care and the usual source of care used by Latino immigrants. Cross-sectional data from the PEW/RWJF, a nationally represented telephone survey of 4,013 adult participants, was used to measure outcomes for preventive care. The study grouped participants by nativity/immigration status with the four categories of US-born, foreign-born citizens, foreign-born permanent

residents and undocumented. Results of the study showed that both perceived quality of care and perceived preventive care were lower in foreign-born Latinos, more so among those with undocumented status (Rodriguez, Bustamante, & Ang, 2009). Compared with US-born Latinos, participants with undocumented status had a significant reduction ($P < .001$) in blood pressure and cholesterol checks, and lower perceived level of care. Legal immigrants were significantly higher in the reception of perceived poor care (38%) compared with US-born Latinos (25%). All foreign-born immigrants reported reasons for poor quality of care were due to inability to pay, racial/ethnic background and accent when speaking English ($P < 0.05$). Strengths of the study were that a large sample of well-defined Latino participants were included, and represented all the Latin American countries of origin. Questions pertaining not only to dissatisfaction with care, but also the reasons for the dissatisfaction were enlightening. Unfortunately a single measurement was used to determine perceived quality of care, and may not explain other problems with unequal care.

Using the PEW/RWJF database, a study by Gonzalez, Vega, Rodriguez, Tarraf, & Sribney (2009), looked at the relationship between health literacy and utilization of a usual source of health care. Cross-sectional, stratified, random sample interviews of 3899 Latino adults were asked about diabetes knowledge and awareness; one-hundred fourteen of the original 4013 participants were excluded after refusal to give key demographic variables. Usual source of health care was associated with higher diabetes awareness and knowledge, and men had significantly less knowledge than women about diabetes ($OR = .064$; $95\% CI = 0.52-0.75$). Findings showed that among the Latino participants, Mexican Americans were more likely to not have a usual source of health care. Reports

showed that lack of usual source of health care was primarily due to lack of insurance and high costs (Gonzalez, Vega, Rodriguez, Tarraf, & Sribney, 2009). A strong point of the study was that differentiation was made between Latinos from different originating countries, so that the participants with greatest need could be identified. This differentiation of demographic data was valuable in that it informed the complexities of Latin American culture, but the study did not lend itself to in-depth knowledge of the immigrant viewpoint. For example, the measurement of diabetes awareness was limited to symptoms, risks and treatments but did not allow open discourse of health topics.

In an attempt to examine whether having insurance affected perceived quality of care, Perez, Ang and Vega (2009) reviewed PEW/RWJF data, and they found that participants with insurance had an odds ratio of 1.47 (95% CI. 1.22-1.76) predictability for perceived quality of care. Those Latinos without insurance had the perception of reduced quality of care and poor health outcomes compared with the insured. Other factors affecting quality of care drawn from multivariate models showed that worse care was perceived by Latinos of Mexican and Central American origins. As in the Gonzalez et al. study (2009), at-risk groups were identified by demographic information. However, the study lacked information on interpersonal information to provide more insight into what quality of care meant to the Latino.

Patient activation, or the ability to manage one's healthcare, has been shown to have positive effects on healthcare outcomes, but little information has been available on Latino patients. Alegria, Sribney, Perez, Laderman, and Keefe (2009) analyzed data from the PEW/RWJF Hispanic Healthcare Survey comparing US born and foreign-born Latinos. Results showed that US-born Latinos scored significantly higher on patient

activation ($P < 0.001$) than their foreign-born counterparts, suggesting that a more thorough understanding of the healthcare system might be beneficial to new immigrants (Alegria, Sribney, Perez, Laderman, & Keefe, 2009), but the scores did not explain what factors were needed to increase activation, a question better served by a qualitative approach.

Studies that looked at cultural aspects of healthcare from the Latino viewpoint, have uncovered issues that affect acquisition of healthcare. This type of study was valuable in that it provided information about basic beliefs in a specific culture in order to provide context for understanding the cultural viewpoint. For example, cultural scripts, or patterns of interaction characteristic to one's culture, were the focus in a study by Triandis, Marin, Lisansky, and Betancourt (1984). In this study, Navy recruits were sampled in three different data sets using questionnaires to test for Latino cultural scripts. The first data set used multivariate analysis of variance, the other two used t-tests for analysis. In all three sets the display of "simpatia", one who has the ability to share in other's feelings, was cited as an important script in the Latino culture (Triandis, Marin, Lisansky, & Betancourt, 1984). Simpatia consistently emerged as an important component of the Latino culture, but since the questionnaires were presented as pen and paper tests, there was no discussion option to allow for additional insights.

An extensive literature review by Flores and Vega (1998) reviewed barriers to healthcare access for Latino children. A MEDLINE search provided 27 articles that met criteria to define barriers specific to Latino children. Sources uncovered several barriers related to Latino children's healthcare: health beliefs, home remedies, folk medicine practices, and sources of parent advice. System barriers consisted of lack of a regular

source of care, type of practice setting, excessive wait, language, transportation and financial barriers (Flores & Vega, 1998). However, the researchers concluded that too little information was available on the parental perspective of major barriers, in particular the nonfinancial barriers, a consideration that perhaps qualitative research could help fill the gap.

Recently research has focused more on the perceptions of participants. A study conducted in southwestern Pennsylvania (Documet & Sharma, 2004) used a combination of survey research and participant observation to explain quantitative findings. Latinos representing 21 countries participated in the study; and were asked about financial and explanatory variables regarding cultural barriers to healthcare access. Analyses using multivariate logistic regression found that cultural issues were more important to the study subjects than were financial barriers. Whereas income and acculturation had no significant effect on outcomes, cultural barriers among the more educated participants included the lack of interpreters during doctor visits, and a Latino preference for “personalismo” (Montoya, 2009), or warm and personable providers. Lower income and less educated participants circumvented the formal medical system by finding providers within their social network and were more satisfied with these alternatives. The practice of finding a culturally appropriate health provider proved to be an important theme in my research as well. Strengths of the Montoya study were that a broad base of Latino countries was included, and that cultural barriers were addressed, but there was a threat to validity due to small sample size, which, reduced generalizability, and results were weighted to reduce bias influence.

In southwest Michigan, Harari, Davis, & Heisler (2008) used semi-structured interviews to explore health care experiences of recently immigrated Latinos. The main focus of their study was to discover perceptions of the subjects with regard to health care access and barriers to meeting health care needs. Inclusion criteria for the study resulted in fifty interviews with Latino immigrants from all Latin American countries, Cuba and Spain aged 18 to 64 years. Although the interviews were semi-structured, participants were encouraged to elaborate on relevant points. Emerging data found themes such as lack of health insurance, language difficulties, and lack of interpreter services, all consistent with prior health disparities research. Social isolation and lack of social networks were identified as more nontraditional barriers linked to new trends in immigration destinations (Harari et al., 2008); although the termed “nontraditional” barriers of isolation and lack of social networks later proved to be the norm during my study, as the location was in a newer destination. Strengths of the study were that participants were permitted to elaborate on topics they felt were important, adding richness to the findings.

An important study by Flores, Abreu, Brown, & Tomany-Korman (2005) focused on issues of uninsured Latino children. Six focus groups were formed in the Boston area and used to examine the perspective of Latino immigrants in relation to health disparities for their children. Twelve participants from two separate communities were divided into small groups; the participants were eligible if they were parents of Latino children who were uninsured for at least six months. The groups were given seven questions and eighteen probes to facilitate discussion. Transcript based analysis was used to highlight themes, which were then validated by consensus. Data from the focus groups revealed

that several factors impacted the insurance gap: lack of knowledge, misinformation from insurance representatives, system problems involving the application process, and “hassles” such as lengthy documentation and lack of response after applications were submitted. Strengths of the study were that analysis was verified by participants for accuracy, and that more than one community was represented. Although a mix of Latino subgroups were involved, not all Latino groups were represented, and might have been a limitation. In addition, Massachusetts allowed noncitizen children to be eligible for insurance, unlike the Midwestern community in my study where lack of insurance for foreign-born children was a major issue. This limitation supported the need for further study.

Brousseau, Hoffmann, Yauck, Nattinger, & Flores (2005) looked at parental perception on the timeliness of care as a quality indicator. Data from the 2000 Medical Expenditure Panel Survey (MEPS) was used to analyze 4120 children from Latino, Caucasian and African American race/ethnicities who had a usual source of care other than the Emergency Department. Multivariate logistic regression was used to model language, timeliness of care and site of care to explain for differences in care. Results from the study showed that Latino children had a lower score for perceived timeliness of care including phone help and wait time ($P < .05$). The disparities persisted after adjustment for language. Strengths of the study were that MEPS is a nationally based target group that supported the concept of timeliness of care is a problem in the healthcare system. Limitations to the study were that children without a usual source of care were excluded, and may underestimate the true disparity faced by Latino children, which a qualitative approach would further investigate.

Hughes and Ng (2003) and Lessard and Ku (2003) reviewed data from a broad array of studies to raise the question of why insurance may not be the only solution to healthcare access for Latino children. While data from the National Survey of America's Families was used to confirm that financial barriers negatively affected children's health, Hughes and Ng (2003) contended that simply expanding health insurance was not the only solution to the problem. They found that disparities persisted despite insurance coverage, and that noninsurance barriers to healthcare stemmed from parental knowledge about preventive care and immunizations, as well as structural barriers to appropriate care (Hughes & Ng, 2003). Lessard and Ku (2003) also reviewed articles of research to find reasons for barriers to healthcare. They concluded that enrolling children in insurance plans was only the first step to fixing the problem. Their findings were that the most significant nonfinancial problem to immigrants was the communication process stemming from lack of interpreters and language barriers. Both quality of care and patient satisfaction scores were affected by the language barrier (Lessard & Ku, 2003). Both articles were strong in identifying problems outside financial barriers, but neither offered concrete solutions, leaving room for further investigation.

A progressive state, California, expanded health insurance to immigrant children through the Healthy Kids program and the Children Health Initiative, attempting to cover children otherwise ineligible for public programs due to family income or undocumented status, for children aged 0 to 18. Stevens, Rice, and Cousineau (2007) examined the program outcomes through semi-structured interviews conducted in twenty-eight California counties, with follow-up interviews one year later. Findings showed that overall the project simplified healthcare for families. Consistency in programs across the

state helped to increase support, but enrollment was capped in some counties due to funding problems. Thirty-seven percent of respondents showed concern for sustainability of the programs, and some reported restriction of undocumented immigrants from the program. Another challenge was provider capacity, or having enough providers for the program; 57% respondents reported problems with adequate specialty and primary care providers. Strengths of the study were that an intervention to increase access to healthcare which included children of immigrants was examined, so that some of the pitfalls could be avoided by other states. However, the survey was limited to California and might not be applicable to other states, especially where foreign-born children were not supported by states programs. This health disparity was a prominent issue in my study.

Research findings on Latino parental viewpoint of vaccinations:

In reviewing studies directly addressing parental beliefs and attitudes toward vaccinations, both acculturation factors and parental beliefs were found to be part of research formats. In 1996, Moore, Fenton and Hepworth compared immunizations rates between Mexican American and non-Hispanic white infants at one year to explore maternal and infant characteristics that could cause immunization delay. Office records, birth certificates and interviews were used for the collection of data from 292 non-white Hispanic and 274 Mexican-American infants; all participants were randomly drawn from Medicaid program. An adaptation of the Acculturation Rating Scale for Mexican-Americans (Cuellar, 1980) was used to rate acculturation, and the Health Belief Model was used as a framework to measure maternal health beliefs about immunizations (Moore, Fenton & Hepworth, 1996). The 5-item scale had a test-retest reliability of .70 ($p=.0001$). A multiple regression model was used to explore differences between the two

groups. Even though the non-Hispanic white infants had higher immunization rates overall, results from the multiple regression model showed that ethnicity was not a predictor of the number of immunizations. Factors that best predicted completion of immunization series were fewer siblings and older maternal age. Maternal acculturation was not a predictor of immunization completion. Strengths of the study were that an established acculturation scale was used for data collection. The household interviews were conducted in Spanish as needed. Limitations to the study were that only Medicaid infants were studied, that would potentially limit generalization to other Latino populations such as immigrants without healthcare coverage. In addition, the study group was limited to a community in the Southwestern United States, and may not correlate with current trends in immigration.

One year later, Anderson, Wood, and Sherbourne conducted a study in Los Angeles to examine the relationship between acculturation levels of Latina women and their children's immunization status (Anderson, Wood, & Sherbourne, 1997). Census blocks with high levels of Latino occupants were used as sampling units, and interviews were done with 688 mothers with children aged 12 to 36 months were randomly selected. A modified acculturation scale based on Cuellar (1980) was used, and was stated to have high internal reliability (Cronbach alpha = .93). Multivariate analysis with logistic regression was performed to produce the study model. Findings showed that 25% of the children were under-immunized according to study criteria. Findings also showed that mothers less acculturated had better immunized children. However, factors such as larger family size, more children under age five and the child not being firstborn, as well as the mother working outside the home led to lower immunization rates. The scale used had

high internal reliability, and similar to the 1996 Montoya study, interviews were conducted in Spanish. It included a large portion of recent immigrants, but did not differentiate data specific to the immigrant group. Findings supported work that family size and sibling position were important predictors of lower immunization rates, but the researchers were more interested in acculturation effect. The study did not address aspects of cultural beliefs or offer new insight into the problem of under-immunization.

Shui, Weintraub, and Gust (2006) studied immigrants from a different angle; they conducted a study to measure prevalence of parents with concern over safety of immunizations and to determine factors that influenced parents to have their children immunized. In Phase 2 of the study, the objective was to explore the immunization attitudes between Latino, African American and Caucasian parents. The Consumer Styles 2004 survey was the database used for this study; 6207 respondents answered the survey, but analysis was restricted to the 2937 respondents with children 18 years or younger. In Phase 1 attitude variables were placed into a logistic regression model to determine characteristics of parental attitudes showing highest concerns about immunizations. In Phase 2 logistic regression for each attitude variable was used to compare differences between race/ethnicity groups. Findings showed that the highest concern included negative attitudes toward immunizations and healthcare providers. The primary reason for immunization was to protect children from disease. In Phase 2 findings showed that African American parents were most likely to have negative attitudes towards immunizations and healthcare providers. The only significant variable for Latino parents was the desire for more knowledge about vaccine ingredients. Strengths of the study were that the origins of the questionnaire were developed from focus group discussion, but

unfortunately the focus group consisted of African American mothers, and did not represent attitudes from the other race/ethnic groups in the study, thereby limiting generalizability. The study failed to capture information specific to the Latino immigrant perspective.

Buelow and Van Hook (2008) also studied parental viewpoint of immunizations by looking at factors influencing timely immunization of immigrant children. The focus of their study was the relationship between parental nativity, residential duration in the United States and citizenship status to timely completion of immunizations in their children, aged 19 months to 5 years. They used data pooled from the National Health Interview Surveys 2000-2003; sample size was 3,947 of which 1,227 were children of foreign-born mothers. Logistic regression models were used to examine variables compared with immunization completion at 18 months. Results showed that having a foreign-born mother with less than five years residency in the United States was significantly statistically negative ($P < .05$) for timely immunization completion when compared to other groups. However, children of foreign-born mothers with 5-9 years residency had immunization completion rates higher than natives. Emphasis was placed on the need to review immunization completion for newly arrived immigrants, specifically those who resided in the US less than five years, and who were more likely to be restricted from public assistance programs. Data from this study is valuable in that it underscored the need for policy changes regarding healthcare access. The analytical sample in the study used children aged 19 months to 5 years old, approximating the area of interest for this literature search. On the down side, the study was focused on parental, not children's nativity, and did not supply information pertaining to foreign-born

immigrant children. Although immigration factors such as citizenship and residential duration were addressed, statistics differentiating between documented and undocumented Latino immigrants were not available. By this point in the literature search, little was found to illustrate the Latino immigrant perspective.

However, a pilot study conducted in rural New Mexico focused on a different approach – this study used qualitative, descriptive techniques to examine perceptions of Latino parents during their encounters with clinic nurses (Keller, 2008). The study group consisted of twelve Mexican American mothers with children aged six months to eleven years old. Interviews were conducted in Spanish or English, by participant preference, and later translated. Emergent themes were analyzed and supported through literature. Three themes evolved from the study: trust in the provider, confidence building in the provider, and language concordance. Trust increased when the provider displayed a sociable attitude, *personalismo*. An unhurried attitude and the provider's encouragement that the mother could take care of her child, built confidence. Supplying information using the preferred language was important to the mothers for making informed choices about immunizations. There was consensus in the group that language concordance was more important than provider race and ethnicity. The other important difference from previous studies was that questions were asked directly of the participants, rather than using a preformatted survey. At least 50% of the participants were recent immigrants, adding valuable data as newcomers to the United States health care system. Limitations to the study were that the group was Mexican American and might not translate to the opinions of all Latino mothers. The subject matter was limited to relationships with providers, and did not address barriers outside that specific relationship (Keller, 2008).

Nevertheless, Keller's study (2008) was an important step in approaching health care directly from Latino immigrant parents, and supported the importance of cultural scripts such as *personalismo*, which was revisited in my study findings.

Summary

The literature for areas relating to the perspective of Latino immigrant parents has been examined in three focal areas: acculturation studies, attitudes towards healthcare in general and parental views of immunization. Acculturation studies showed consensus in the concepts of health disparities and barriers for immigrants in terms of access to care, health policy, and duration of residency as related to the acculturation process. The studies were structured with Spanish translation that showed a consistent cultural sensitivity to participants and promoted understanding of the research questions.

Consistency between researchers of the JGIM supplement was seen by the use of the same database for analysis. Results from JGIM studies agreed that initiatives were needed to reduce healthcare disparities for Latino immigrants, specifically in the areas of quality of care, preventive care, source of health care, insurance and patient activation. Consensus among studies pertained to general healthcare perspectives confirmed what was already known about barriers that Latino immigrants faced, including financial and language deficits, poor translation services, long waits and inadequate information about health services. Cultural scripts such as the importance of *personalismo* and *simpatia* supported existing knowledge.

Among studies on attitudes towards immunizations, there was a general consistency in the use of nativity and length of residency to examine immunization

completion. The studies also reflected cultural sensitivity by having materials available in Spanish. The lone pilot study that examined immigrant perception of providers supported known cultural expectations such as *personalismo*.

Areas of disagreement or debate were mostly found in methodology, research design and the importance of findings. In the acculturation studies different independent variables were used to analyze acculturation demographics, that ranged from maternal nativity, maternal and child nativity and subjects over the age of eighteen. This inconsistency made it difficult to compare findings.

The JGIM supplement articles had no specific areas of disagreement, although each represented a different area of concern for immigrants, i.e. quality of care, source of healthcare, health literacy, effects of insurance and patient activation. Major differences between other studies on the immigrant perspective of healthcare were seen by the methodologies chosen, that ranged from pen and pencil questionnaires to open-ended interviews with focus groups. Even though these differences were evident, they were not detrimental. Instead, the use of varied methodologies helped to approach the question of the immigrant perspective from different angles, thereby enriching the findings. Perhaps the most beneficial outcome from using different research modalities was that nonfinancial and noninsurance barriers were explored. Qualitative studies by Harari et al.(2008) and Flores et al. (2005) informed about barriers to immigrants who arrived to nontraditional destinations, concerns that were not voiced in studies about traditional Latino communities such as California, where the focus was on insurance programs (Stevens et al., 2007).

Between articles specific to parental attitudes towards immunizations, the main difference was seen in the target populations. Two studies examined the Latino population in general while the other three studies selected immigrant subjects and addressed their specific concerns. Methodologies between the articles differ; four used quantitative analysis and the fifth had a qualitative design. The philosophical perspective also differed as three studies were based on acculturation theories and two actively explored parental attitudes and concerns about immunizations, and their experiences while obtaining immunizations for their children.

After a critical review of literature relating to research on the Latino immigrant perspective of healthcare and immunizations, knowledge gaps remained. Acculturation studies validated the needs of Latino immigrants, but do not explain why, in spite of this knowledge, disparities persisted. In fact, two of the articles (Weathers et al., 2008; Uretsky & Mathiesen, 2007) suggested that further qualitative factors influencing parental perceptions and research on children were needed. The JGIM series presented excellent documentation on the Latino immigrant perspective, but the authors stated that more research was needed as data was based on limited questions that did not adequately represent the full Latino viewpoint. The use of a prepared telephone survey in acquiring data did not allow for an open exchange of ideas. The original data from PEW/RWJF had information on usual place of care such as *curanderos*, and alternative treatments, while not addressed in the JGIM supplement, added valuable insight to understanding the Latino perspective (Livingston et al., 2008).

The Flores and Vega (1998) review concluded that there was a general lack of information about parental perceptions of barriers to healthcare for their children,

especially regarding nonfinancial factors. Studies that attempted to answer these questions had their own foci and fall short of closing the gap. Documet and Sharma (2004), Stevens et al. (2007) and Flores et al. (2005) focus on financial barriers, while Brousseau et al. (2005) were concerned with timely care and systems problems. Harari et al. (2008) looked into the problems of newly arrived immigrants in nontraditional destinations such as the Midwest, and conducted a qualitative project that identified some valuable issues adding insight into the immigrant mindset, but needed further development.

Articles designed to directly address Latino parental attitudes toward immunizations were disappointing. Anderson et al. (1997) examined demographics and ignores cultural beliefs, whereas Shui et al. (2006) based their study on opinions from an African American focus group that they try to portray as a reflection of Latino and Caucasian parental concerns. Buelow and Van Hook (2008) considered only parental nativity, and not children's nativity, as a crucial variable in their immunization design, thereby bypassing information pertinent to immunizations of foreign-born children. The pilot study by Keller (2008) offered insight into Latino immigrant mothers' relationships with healthcare providers, but offered a narrow glimpse of what other factors might influence parental decision-making with regard to immunizations.

Overall, the quantitative research served as a background to test acculturation theories, and confirmed what was known about health disparities among Latino immigrants. Those researchers who used concepts of acculturation and assimilation tended to utilize preconceived foci that did not always reflect the immigrant perspective. New trends in immigration, with migrants moving into unchartered new destinations, did

not fit into theories of social capital or social networks, as there were no existing Latino communities at the receiving sites. Medical research articles such as the collaborative supplement in the *Journal of General Internal Medicine* used data-driven surveys to represent the immigrant perspective (Rodriguez et al., 2009) and did not allow for open discourse of issues.

After this initial review I found that the literature provided background information regarding the Latino immigrant in the United States, and a cultural context to describe the phenomenon of immigrant families, but there were still pieces missing. These missing pieces helped to formulate my research question: What is the lived experience of obtaining vaccinations for their foreign-born children from the Latino immigrant perspective?

My initial intent as a student researcher was to conduct a questionnaire based on known barriers to see if these reflected the experiences of Latino immigrants. In fact, I considered a quantitative study with the objective of supporting a mid-level theory about immigrant self-efficacy. All the while I had the nagging feeling the questionnaire approach would not answer my research question; as a former immigrant and one experienced in the Latino culture, I had strong feelings that valuable information was missing and that a questionnaire would prove to be inadequate. I began to explore other research methods. I enrolled in a qualitative research course and during my first interview of an Hispanic immigrant, I confirmed what was missing: the experience of the immigrant from his own perspective. Although I did not know at that time, I was only seeing the tip of the iceberg. Only after developing and conducting my own research I discovered the 90% of Latino immigrant concerns that lay beneath the surface. I explored

the various qualitative methodologies as outlined earlier in this chapter, and concluded that interpretive phenomenology would provide the best strategy to reveal the unknown, to inform my research question, and ultimately, to better serve the Latino immigrant population.

Conclusions

Although qualitative studies using focus groups or ethnographic orientation have reaffirmed known cultural and health practices of Latino immigrants, little attention has been focused on immigrants' experiences in new destinations, and the challenges they have faced when seeking healthcare for their families. Parental factors affecting the acquisition of vaccinations for legal Latino immigrant children have not been adequately understood, as the disparities in immunizations for the population persist. Further research is needed if parental factors are to be explained and understood.

An appropriate methodology to find unbiased themes in the lived Latino immigrant experience is phenomenology, the "study of the individual's life-world, as experienced rather than as conceptualized, categorized or theorized. Phenomenological research is the study of essences of experience. The aim is to understand the experience" (Munhall, 2007, p.163). Phenomenology has become a popular qualitative research method for nursing because it is recognized as a method without an agenda. Preconceived theories are placed aside and subjects are permitted to speak at length about their personal experiences. Current researchers who chose the phenomenological method do so "in the belief that essential truths about reality are grounded in lived experience" (Speziale & Carpenter, 2003, p.65). Themes that emerge from phenomenological inquiry are used to

understand and explain findings. Conducting phenomenologically based research benefits not only the immigrants it serves, but broadens the science of nursing by providing insight into the lived experiences of immigrants as they face the US health care system. It brings into focus issues through the lens of first generation immigrant parents who are attempting to obtain health care for their children, and enlightens providers on problem areas. By sharing their experiences, the immigrant parents provide a clearer vision of the effect from individual, community and policy factors. Providers who review the study are in a better position to improve outcomes for this group of patients. Nurses, in the advocacy role, can continue to be a voice, an informed voice, for this vulnerable population.

CHAPTER THREE

Methods

Interpretive phenomenology encourages the researcher to dwell within the data and become a part of the world of the participant to gain a better understanding of his/her experience (Benner, 1994). This chapter provides a brief discussion of the methodology of interpretive phenomenology used to guide this research. Participants were recruited using purposive sampling (see Procedures).

Participants

Sample criteria and justification: A purposeful sample was obtained from participants of the immigrant Hispanic population identified through clinics and churches. Participants were recruited by designated IRB-approved contacts at different venues to avoid obtaining a homogenous group and to prevent sampling bias towards persons with established medical providers. When discussing findings, the characteristics of the sample were emphasized to show representation. Limitations were that there will be those who did not obtain vaccinations and did not wish to participate in the study. The actual sample size was 11 Hispanic immigrant parents residing in a central Midwestern state.

Inclusion criteria for the participants:

1. Participants were Hispanic immigrants who have experienced needing immunizations for their foreign-born children during their first 5 years residing in the United States. This included those who had not yet sought or obtained immunizations, as well as those who have been successful.

2. Participants were age 18 years or older and parent of foreign-born Hispanic children.
3. Participants were able to read or understand either English or Spanish and could complete the consent form at the site of recruitment

Exclusion criteria:

1. Participants did not include immigrants married to US citizens if the US spouse was a parent of the foreign-born child.
2. Persons who indicated they had not experienced seeking immunizations for their foreign-born children after immigrating to the United States.
3. Persons under the age of 18 years.
4. Persons who were not able to read or understand English or Spanish.

Procedures

Participants were recruited through healthcare providers, local clinics and churches, as well as public flyers or church bulletins. I trained potential recruiters in the objectives of the study and they were pre-approved for participation by the IRB.

Handling of all data was by IRB approved persons in order to ensure confidentiality.

Feasibility of recruitment: The sample was recruited by invitation to potential participants when visiting one of the following locations; selected clinics or churches in central Indiana. A key person at each location was trained by the primary investigator to identify possible candidates based on the inclusion criteria. Each location had a minimum goal of 3 and the maximum goal of 10 recruitments to ensure some heterogeneity of the sample. Participants received a \$15 local retail store gift certificate as suggested by a contact of the recruiting agency to be offered at completion of interview as

reimbursement for participant's time. The contact felt this amount would not be coercive to this population.

Setting: The setting for this proposal was a community-based agency and a local Hispanic church where qualified persons were recruited for the study. I interviewed participants in their choice of English or Spanish, nearly all chose Spanish. Each participant was read a statement of confidentiality and privacy, and the informed consent. After consent was obtained, each participant participated in a face-to-face unstructured interview lasting between 60 to 90 minutes. Interviews were recorded on a digital recorder. The location of the interview was of the participant's choosing, in the home, agency or church affiliation, as long as the location was safe and private.

The Hispanic church was a non-Catholic Christian organization located in an urban neighborhood. The congregation consisted of immigrant families from all over Latin America including the Caribbean islands, Mexico, Central and South America. Study participants from the church were interviewed in their own homes at the time of their choosing.

The community agency was located in a small rural Midwestern town. Clients of the clinic also came from Latin America and used the clinic for medical and/or spiritual purposes, as the agency did offer faith based services. Vaccinations were given at the clinic of certain days by the local health department. According to the agency director, this practice started when an Hispanic family was stopped by local police while on their way to receive vaccinations at the health department. After that experience, the health department agreed to host vaccination days at the clinic to avoid what was perceived as a profiling experience. In my study, participants were interviewed at the clinic during

business hours. Positioned outside the clinic was a sign with the words “Safe Place” printed. Although the sign was placed to designate that children would be safe while trick-or-treating during Halloween activities, it seemed to signify much more. Here was a safe haven where immigrants could go for help and feel safe from judgment, prejudice or legal scrutiny. To a researcher, it was also a safe place to interview participants, out of reach from human traffickers who might be lurking near the participants’ residence, according to the agency director. This situation was in stark contrast to the church participants whose homes were considered safe by their recruiter.

The study conversation with participants started with probes designed to stimulate conversation for this unstructured interview. Potential probes included:

- Tell me about a time when you needed to find vaccinations for your child.
- How is it that vaccinations affect your health.
- Tell me about vaccinations in your home country.
- How is it that vaccinations are or are not beneficial.

Protection of Human Subjects

Human subjects’ approval: minimal risk of harm or discomfort was anticipated, and no invasive procedures were used. The risks were low and primarily involved risk to confidentiality. The consent was available in English or Spanish and participants were given plenty of time to read and ask questions before signing the consent. I read the consent form and explained the study for potential participants with low literacy. Each participant was given a unique pseudonym to protect confidentiality. All data was de-identified. Interviews were digitally audiotaped and kept secure on a burned compact

disk. As soon as transcripts were transcribed and validated with the recording, I destroyed the recordings as per IRB protocol.

Measures

Demographics: Demographic data for participants were age, gender and education. Data for Hispanic immigrant children was also collected as age, gender, Hispanic or not, and race. General demographics such as level of education were asked, but no identifiable information such as address was used. IRB-approved persons involved with transcription and translation did not have direct contact with participants. Only de-identified data was shared during and after completion of the study.

Data Analysis

In phenomenology, the first level of analysis actually occurred during the interview, as I heard the responses and adjusted probes to allow participants to expand on their thoughts. The next step was to transcribe verbatim each interview and then to translate it to English, if the interview was in Spanish. The use of a professional transcriptionist for typing the recorded Spanish was enlisted to facilitate change of digital data to written data. An IRB approved transcriber assisted in the initial translation of Spanish to English. I reviewed each transcribed and translated interview word for word, to assure accuracy and meaning. I listened repeatedly to review each interview, allowing for refinement of probes as themes began to emerge from the data. I highlighted what I perceived as important in each interview, and then I categorized the highlighted material according to topic, creating the beginnings of a coding system. As the interviews were completed I looked across the data to find similar themes, and designated a color and

code for each theme. I used MAX-QDA software obtained through IU School of Nursing license to help organize and de-identify data. Immersion in the data furthered the process of identifying themes and patterns as they emerged (Sloan, 2002). In this way I was able to analyze the transcripts as a whole. The findings helped explain the experience of the immigrants from their perspective.

Rigor

While quantitative studies are evaluated for validity, in qualitative work one looks for the credibility or trustworthiness (Speziale & Carpenter, 2003) of the research. In this study, credibility is derived by inclusion of only those who have lived the experience. Prolonged engagement with subjects provided support for credibility. Quantitative studies are also evaluated for reliability. In qualitative work one seeks consistency in findings between participants, and with consistency of what stands out as important among readers of the interviews. When adequate consistency is found, the data is considered saturated (Speziale & Carpenter). Data for this study was shared in an IRB-approved Hermeneutic circle, a team of experienced qualitative researchers and graduate students, who discussed both verbally and in writing, passages from the transcripts that stood out as important to understanding the participants' experiences. They also assisted in interpretation by identifying concepts from philosophy, literature, poetry, and music that may be helpful and checked for and protected against bias. Quantitative studies look for usefulness of findings. In qualitative work one seeks the usefulness of research in other settings. This finding is determined by the readers of research, not by the researchers.

One aspect of usefulness in studying lived experiences of Hispanic immigrants is that findings may be transferable (Polit & Beck, 2004) to other immigrant groups.

In my research, during data generation I established credibility through persistent observation and prolonged engagement, or dwelling in the data. I maintained verbatim recordings of interviews using a voice recorder to record both the interviews and field notes. Credibility was maintained during data management by transcription rigor: the recordings were prepared into Word documents so they could be reviewed verbatim. Likewise, all translations from Spanish into English were carefully and methodically reviewed for accuracy. Integrity of the data was maintained by a systematic audit trail by preparing separate folders that contained field notes, transcriptions and translation for each participant. In the data analysis I used peer debriefing through the Hermeneutic Circle as a means to check consistency and to protect the data from researcher bias. For the report preparation, I performed a second literature search to support interpretation and findings, and to find evidence supporting my interpretation. Usefulness of my research will be determined by its readers.

Summary

The significance of the study is that data may be used to give insight to the effects of individual, community and policy factors on the experience of obtaining vaccinations for immigrant children. Providers who review the study will be in a better position to improve outcomes for this group of patients. Data may indicate a need for intervention by stakeholders such as the Immunization Coalition, public health offices, schools, or policymakers.

CHAPTER FOUR

Data Analysis and Interpretation

The purpose of using hermeneutic phenomenology in qualitative research is to reveal what is concealed. Interpretation by use of Heideggerian philosophy further helps the reader gain understanding and knowledge of the data findings. Past research has provided information and statistics about barriers to healthcare encountered by immigrant families, but has barely scratched the surface of the Hispanic immigrants' lived experiences. Through interviewing and interpreting the narratives of Hispanic immigrant parents who have children needing vaccinations, I gained an understanding of their world. Findings in my research revealed the overarching theme of *trust*, and how trust plays a role in how Hispanic immigrants perceive and receive healthcare. With trust as the overarching theme, my findings also included the subthemes of health literacy, health disparities, the importance of a medical home, and preservation of a healthy family unit.

To explain data findings, the qualitative researcher often uses a metaphor in order to facilitate the reader's understanding of complex issues. I have used the metaphor of an iceberg, where the initial study began with interviewing about vaccination experiences, and proved to be the tip of the iceberg. During the first interview I became aware that much larger issues loomed beneath the surface, hidden from view, but too large to be ignored.

The Metaphor

“Picture an iceberg. The bulk of its power lies below the surface. The part of the iceberg that sunk the Titanic, for example, was not the 10 percent above the water; it was the 90 percent below the surface that did the damage. For human beings, it is also often true that the 90 percent below the surface our unconscious beliefs, attitudes and habits sinks our fondest hopes and dreams.” (White, 2012)

I started the interviewing process with four main probes, based on the experiences of Hispanic immigrants obtaining vaccinations for their foreign-born children. During the very first interview, it became obvious that in terms of health care and health concerns, vaccinations were just the tip of the iceberg – what is seen above the water publicly as a means to assure that children have met basic prevention requirements for entering school.

The *body* of the iceberg is submerged, hidden from public view, and lies beneath the water. This is the larger part of the iceberg's structure, and it is here the iceberg lives privately with all its components, just as the immigrant family has a private, unseen family life. Aside from the physical structure is the iceberg's journey. It may be adrift at sea, or become connected to an iceberg community. An iceberg is affected by its external environment and may remain whole or break apart due to fractures caused by external forces or pressure from within, or can suffer a meltdown. Similarly, immigrant families are affected by political and health agendas, and are faced with decisions, whether to stay adrift on the fringe of society, to immerse the family into a community, or to return to the country of origin when external pressures become too great. However, sometimes cracks in the ice can refreeze and reinforce the strength of the iceberg, just as adversity can strongly unify a family.

This is a story of the journey of Hispanic immigrant families through treacherous waters. In the first stop along the way, they come upon the tip of an iceberg, an introduction to healthcare in the United States, by way of vaccinations for their children. As the story begins, we are in the living rooms of Hispanic parents while they share their thoughts and experiences of obtaining vaccinations. The first theme that emerges is

health literacy and beliefs about vaccinations, accompanied by our first glimpse of the overarching theme, trust.

Tip of the Iceberg

Dispelling the Myth – health literacy

Hollywood has a history of portraying Hispanic immigrants in a negative stereotype, often as uneducated and “unable or unwilling to help or speak for themselves” (Vargas, 1998, p. 408). Cartoonists often depict a rotund Hispanic male reclined in siesta under a Saguaro cactus in contented repose, wearing a serape and a large sombrero. This image is supported by stereotypic verbiage such as lazy, ignorant, or shiftless. These media images and misrepresentations support the concept that immigrants have low health literacy, but especially where vaccinations are concerned, this is not reality. The World Health Organization (WHO) describes a person with adequate health literacy “as having the cognitive and social skills to access, understand and use health information for health promotion and prevention” (Ingram, 2011, p. 696). The data consistently portrays an understanding of the purpose and need for vaccinations, as illustrated by Hispanic parents.

One surprise from my research findings was the consistency of knowledge and acceptance of vaccinations by participants, regardless of their education or socio-economic backgrounds. While society generally perceives the less educated or poor to be less informed, the interview process revealed the opposite to be true.

Responses of Hispanic immigrants when discussing their perception on the need for vaccinations helped dispel a common myth, that Hispanics immigrating to the United

States do not understand the science or the need for vaccinations. This myth, dispelled by every participant regardless of formal education, was most eloquently stated by Juan (pseudonym), from Central America, who explains his concept of a vaccination as follows:

Juan: Shall we say that a vaccination is a virus from a nearly dead virus of the same illness, and they take a sample, then the body itself creates antibodies.

Originally from Mexico, and a mother of three children, Linda further dispels the myth of medical ignorance through her response:

Interviewer: What do you think about the effect the vaccinations have on the health of your children?

Linda: I think that it's good to vaccinate them; it's good to vaccinate them to prevent diseases. Just like there in Mexico. There are some people who don't get vaccinated. They don't get vaccinated because they have ideas, and they don't get vaccinated. I saw a person, a lady – they say she'd never been vaccinated and she had polio... it was because she didn't get vaccinated.

At the other end of the socio-economic spectrum was Cesar, a Mexican-born laborer who had such difficulty reading that I had to read him the research consent form. In spite of his obvious lack of formal education, Cesar answered no differently than other participants in terms of his knowledge about vaccinations.

Interviewer: What do you think about vaccinations?

Cesar: I do it (obtain vaccinations) for the benefit of the little girls' health... they need it in order to avoid childhood diseases.

Heidegger states that humans are fore-having, or having a world view, something one has in advance (Being and Time, p. 191). By being-in-the-world, one has an understanding of his world, his Dasein, or everydayness (Being in the World, p. 13). From these interview

excerpts one has evidence of the worldview of Latino immigrant's knowledge and attitude toward vaccinations. Obtaining vaccinations for children is an accepted part of everydayness from the Latino immigrant perspective.

Another key factor pertaining to vaccinations is understanding the process and the importance of record keeping. During one interview, Marisol, who came with her daughter from Mexico in 2000, explains her understanding of the vaccination process:

Marisol: Well, there, when they give vaccinations, they give them to newborns and again when they are about three months old, and from there at six months. Vaccinations every three months...

Carmen, also from Mexico, explains the importance of keeping the vaccination record readily available:

Carmen: I have a paper. I have the paper where all the vaccinations are listed, because they ask you for it. When you go into first grade they ask you for it, and the second year they ask you for another record that proves you got them, but they (the school) ask you for it regularly.

Up to this point in the story, events have run smoothly, and the immigrant families receive the healthcare they anticipate. However, the process is not always positive, as we soon will learn from other participants who had negative experiences while seeking vaccinations for their children.

Trust

Coupled with health literacy and competence is the importance of self-efficacy. "Self-efficacy is the confidence a person feels about performing a particular activity, and supports the belief that individuals have control over what they do, Bandura, 1997" (Ferguson, 2008, p. 292). When one has self-efficacy, one has self-trust that enables

him/her to carry out activities such as providing immunization records for health care providers. Not only are immigrants well informed and supportive of vaccinations, they are also proactive in bringing immunizations records from their countries of origin. Unfortunately, the documents are not always honored. Again we hear from Linda, this time regarding an unpleasant revaccination of her children, by a health care provider who did not trust previous vaccination records.

Linda: I have three children...all three are from there (Mexico).

Interviewer: And before coming (to the United States), they had vaccinations?

Linda: Yes, before we came (to the United States), as soon as they are born, they give them (the children) vaccinations...Two months later they get another (vaccination), and then at six months they give them (the children) another (vaccination). At one year old, and so on. They vaccinate them there (in Mexico) but, um, when we got (arrived) here (in the United States), they (health providers) gave them (the children) all the vaccinations again.

Interviewer: Oh, really? What, you did not have a paper that had the vaccinations (recorded)?

Linda: Yes, I brought it (the vaccination document from Mexico), and I showed it to them (health provider), but they said it was a requirement to vaccinate them again. From their first vaccination, as if they had been born here, all the way up to the age they were then. Each one. The little girls had, if I remember right, five or six vaccinations.

A similar incident occurred when Carmen brought her daughter to a clinic in Northern city; she did not have a written vaccination document, and her word was not sufficient:

Carmen: I have a daughter. Her name is "Ana Maria"(pseudonym); she was born in Mexico, and she arrived here six years ago.

Interviewer: ...when she was a baby, did she have vaccinations in Mexico?

Carmen: Yes, they gave her all the vaccinations in Mexico. When she came to the United States she doesn't (did not) have a record because, logically, she wasn't born here, so, some vaccinations that they had already given her in Mexico, they had to give her again in the United States in order to begin to have a record.

Carmen interpreted this action as a breach of trust between patient and health care provider, the provider in lacking trust in the parent's verbal health history, or even of a foreign document as in Linda's case. Heidegger would describe this interaction by his definition of being secure within the fourfold. In this analogy, the immigrant portrays the "mortal" or human condition, and the health provider represents the power in the relationship, or the "immortal". The other two parts of the analogy are the "earth" or what one knows, and the "sky", or the unknown. Due to ever dynamic fluctuations between the fourfold, the mortal, or immigrant, finds that *trust* becomes an essential part of preservation of the fourfold. In the fourfold the immigrant exists or dwells in the trust that those in power, the health care worker, will act in the best interest of the children. Revaccinations and non-acceptance of documents cause a rift between immigrant and health care worker, and threaten the relationship of the fourfold.

In instances where there is trust between health provider and immigrant, a trusting relationship is more likely to develop.

Interviewer: When you came to Western state, what did the doctors say to you. That the vaccinations are now the same, or are they different between the two countries?

Juan: That they are the same. Anyway, they asked us for a letter verifying the vaccinations. But since we hadn't brought it along with all his medical records, they, we presented the records to them, and they made a new record, including all the vaccinations he already had and the ones that he needed.

Interviewer: Very good. So he did not have to repeat any?

Juan: No. They said that there was no problem. So he didn't have to repeat any (shots).

Linda, Carmen and Juan all acted in good faith as parents who sought vaccinations for their children, yet all three had varied experiences in terms of documentation and revaccinations. This tiny slice of human experience points to a larger question about consistencies in medical practice. It raises concern that even a well-documented vaccination record may or may not be considered sufficient depending on the health provider, as opposed to having a standardized practice.

The act of seeking and receiving vaccinations is a visible, public action, witnessed by nurses, schools, measured statistically (HP2010), and supported by public policy. This visible interaction with the health care system, whether positive or negative, is only the tip of the iceberg. As the interviews unfolded, I found that although the participants willingly shared their experiences in obtaining vaccinations, they were also open to discussing other aspects of health care that proved to be more troublesome, problems less visible to the public eye.

During the interviews, several participants discussed their personal experiences with the health care system, beyond obtaining vaccinations for their children. To the Hispanic immigrant, trust is an important value, and its assurance is a vital cultural aspect. As discussed in the anthropologic literature review, Marisol confirmed the importance of kindness, or the essence of *simpatico*, an important trait that builds trust in Hispanic patients, and what it is to be an Hispanic immigrant in current times.

Interviewer: As nurses, what can we do to improve your experience, when you go to visit (the doctor)?

Marisol: Well, they (nurses) could treat a person as nicely as possible, right? That's what I think...I understand that sometimes there are a lot of people and you can't help everyone at the same time. But they (nurses) should be nice too, and should also ...have patience.

Lourdes had come to the US approximately 10 years ago from South America. She was well educated, and even had started a career in her country, but her husband came to the US and she followed one year later with her young daughter. Since that time Lourdes had two more children who were born in the US. Her home was a single family unit in a middle class neighborhood; it was well decorated and modern. The interview took place in the front living room, where there was a large, comfortable couch, and a glass topped coffee table with carefully arranged fashion magazines. As I chatted with Lourdes in her living room, she provided great insight in every day terms why trust is significant to the Hispanic culture:

Lourdes: And they (health providers) ask you "Are you having pain? Can I get you something to ease the pain or ...?" But there are those others who don't. They leave you there. And that's difficult.

Interviewer: From this study, I have found that being nice (concept of simpatico) is very important.

Lourdes: Yes. Because it gives you more trust and more reassurance in a situation. It's just that, when your family member is sick, you are going to be more tense. Then, if they treat you well, they're cordial, they give you that trust that allows you to be calm and to believe that they're going to tend to you better. But if they treat you poorly, and you are the well person, well, imagine what a sick person would do. It's not going to be the same.

Lourdes also recounted the experience of taking her son to a local emergency room for blood tests, and how that experience lead to her *distrust* of the facility:

Lourdes: I don't know if the person (health provider) he got that day wasn't in the mood, or anyway, I don't know. The deal is that he couldn't

draw blood. After trying four times, she stuck him in another place, and nothing. But he was fighting. That is, he was putting up a fuss. That was the worst experience I had, because to see my son yelling while they were sticking him here and there, and I finally said, “That’s enough. Don’t draw his blood. I don’t want anything.” And it ended. And since then, I’ve never gone back there.

Heidegger does not specifically discuss distrust, but he does describe affectedness or cultural sensibilities, which affect how one is open to “that what it encounters within-the-world” (Heidegger, 1962/2008, p. 176). In the matter of trust versus distrust, Lourdes is subject to distrust those who do not project kindness or being *simpatico*.

What Lies Beneath

From *The Prophet*

“Say not, ‘I have found the truth,’ but
rather, ‘I have found a truth.’
Say not, ‘I have found the path of the soul.’
Say rather, ‘I have met the soul walking
upon my path.’
For the soul walks upon all paths.
The soul walks not upon a line, neither
does it grow like a reed.
The soul unfolds itself, like a lotus of
countless petals.”

Kahlil Gibran (1883-1931)

Revealing the Concealed - health disparities

Returning to the analogy, the vast part of the iceberg is hidden under the water line. Freud likens the human mind to an iceberg, where the tip represents the conscious mind and under the water, hidden from view, resides our preconscious and unconscious mind and “contains our instincts, passions and fears” (Iceberg Analogy, 2012, p. 1).

During conversations with immigrant parents, “the soul unfolds itself” and concealed concerns are revealed. Once the initial small talk and questions directed towards vaccinations were completed, I asked more sensitive questions, especially in

light of the current political climate revolving around immigration issues. One issue that was echoed across interviewees was that of health disparities, both within the nuclear family and in the larger community.

Several study participants have children both born abroad and in the United States. Children born in the United States are automatically US citizens, which qualifies them for insurance such as Medicaid and SCHIP; whereas, their foreign-born siblings are relegated to emergency-only Medicaid. This disparity has led to angst within the nuclear Hispanic immigrant family. For example, when Lupe migrated to the US from Central America, she brought along her seven month old son; her daughter was born later in the US. During her interview Lupe brought up the topic of disparities for health care access between her two children.

Lupe: My girl can go everywhere, yeah, to whatever doctor she wants, but the boy can't; only to certain places that belong to the county.

In a similar manner, Maria's son was three years old when the family came to the US from Mexico. She voiced concern when asked about her son's health care access:

Maria: Medicaid for emergencies only covers him if there is some accident. Some, something like an illness that he gets suddenly and he has to go to the emergency room.

These sentiments were echoed by Mexican born Marisol, mother of three, who expressed strong feelings about disparities she had seen the health care for her children:

Marisol: Children who are born here have more benefits than those born out of the country, but let's say, the ones who are born here, they help them, with food, and they have their Government insurance for normal appointments and for emergencies. Those born outside, they don't, because it's only for emergencies. It doesn't cover normal appointments.

In the Dasein, or everyday world of the Hispanic immigrant parent, healthcare disparity is a source of worry. According to Heidegger, worry or concern is characteristic

in Dasein of the caregiver, in this case, the parent (Heidegger, 1962). “A particular Dasein can make itself at home in the world... or it can become paralyzed in anxiety and thus only clutch at things” (Dreyfus, 1991, p.223). Lupe discussed how she worried about her son’s health due to the difficulty in obtaining health care:

From my point of view as a mother it’s a bit sad. Because I can’t tell my son, ‘don’t get sick because you don’t have right to a doctor’.

Maria also lamented the differences between her children’s access to health care:

Maria: The little girl has access to all kinds of health care, and the boy doesn’t, because he doesn’t have documents... well, I can’t take him to regular appointments here, like the girl. It’s difficult that way.

However, without the opportunity to express their views on this worrisome topic, immigrants remain silent and invisible, and this steals their personhood. Benner describes one aspect of personhood “The Person as a Being for Whom Things Have Significance and Value” (Benner, 1994, p. 49). The Hispanic immigrant mother understands from her Dasein, the values of her culture, that nurturing children is an important aspect of motherhood. The inability to find adequate health care causes great angst; her personhood is stolen because she has nowhere to voice these concerns. Further damage is done because she becomes inauthentic to what she would normally do in her country of origin. The essence of freedom, of truly being oneself, or Authentic (Heidegger, 1977), is shrouded in a silent undertone of acceptance, contrary to the “American Dream” of freedom. The new truths that immigrants face is that in caring for others (children), for some there are limited possibilities, whether in the form of denied insurance and health benefits, or for older children who seek advance education.

Aside from vaccinations and basic healthcare, as the children grow to adulthood, dreams of a higher education are often dashed due to denial of federal student loans and

scholarships, if one is not a US citizen. (Dream Act, 2010). I mention these facts, perhaps as outliers to this particular study, but they are concerns that affect immigrant life and cannot be ignored. Benner writes about inheriting a diminished future, as expressed here by Lupe:

Lupe: We immigrants know of course that we do not have all the benefits of a person who is a citizen or who is born in the United States.

Lourdes knows all too well the limitations placed on her foreign-born children:

Lourdes: You feel helpless, that sometimes you can't do something.

The ability to place trust in a better future for their children, whether in terms of health care or educational disparities, are not the only concerns revealed during the study. It is a common expectation that through the open-ended questions used in qualitative research, new questions or probes will emerge. As questions during my interviews expanded to topics such as the immigrant's perception of US health care in general, participants revealed their own personal experiences that portrayed what it is to be an immigrant in today's health care system.

Interviewer: Where did you go if you had a health problem?

In response to this question, Juana, now a mother of four, responded:

Juana: Well, I didn't go anywhere, (I bought) medicine from the pharmacy but I didn't go to any clinic.

Juan had come to the US for work, and yet was unable to obtain insurance for himself and his wife:

Juan: We didn't apply for ourselves, excuse me, we didn't qualify. Yes, we did apply but we didn't qualify.

Carmen described how she managed to survive outside a system based on insurance in order to meet her health care needs:

Carmen: You don't have insurance, you look for something where you can go. Later when they give you the prescriptions for you to go to Walmart... they give you discounts.

Without a medical home there is no "usual place" for healthcare, where individual records are kept and health issues are monitored. On the fringes of society, those without insurance are permitted to receive medical services in the emergency room, by law Emergency Medical Treatment and Active Labor Act (EMTALA), passed in 1986, (Center for Medicare and Medicaid Services, 2001), they cannot be denied. Studies have shown that although immigrants have the right to attend the emergency room (ER) for medical care, they are far less likely to use the ER than their insured counterparts (Cunningham, 2006). This habit further alienates them from medical care, emergent or otherwise.

Rather than experiencing an environment of trust in health care, there appears to be stigma of being alien and receiving different treatment. Even if long waits and poor services are not the intention of healthcare institutions, inferior treatment is perceived by immigrants who do receive services. Linda was visibly wrought with emotion as she recalled her experience as a patient in the local emergency room:

Linda: Sometimes you go to the hospital (emergency room)...they left us until past... I was waiting there for who knows how many hours... my brain hurt so much that I couldn't stand it...(the nurse said)'go home and try to calm down'. They didn't even give me a pain pill

Along the same lines, Lourdes experienced long delays in services which she perceived as related to language barriers, and she compensated by accepting substandard service. Lourdes, speaks limited English, yet she sacrificed the right to an interpreter in order to avoid delaying services for her child in the emergency room:

Lourdes: If I am short on time, then I tell them 'OK....'

Fortunately the resilient immigrants in this study began to recognize poor services and found clinics that met basic health needs including immunizations and childhood development concerns. However for most of their foreign-born children, specialists are still out of reach, as detailed by Lupe:

Lupe: ... there are doctor specialists in some hospitals that only accept regular Medicaid, the Medicaid of a child that is born here, and the emergency Medicaid for immigrant children is not accepted.

The Journey

Excerpts from Sonnet 16 from Chinese book of poetry:

“We stand together on a mountain’s crest
projecting vision far across the steppe
till sight is lost in distance, or else rests
where paths spread on the plain and intersect
We are the footpaths that crisscross on the plain
and are the people traveling on them.” Feng Zhi(1905-1993)

Finding Their Way- the medical home

Just as the iceberg calves off from a glacier and begins its journey, the immigrant family breaks away from all that is familiar and “ready at hand” to journey forward into an unknown future. To a family, preservation of the family unit on this adventure involves searching for things that have significance or meaning, such as cultural values, i.e. finding a church, extended family and/or community. For our participants, becoming reestablished in the United States was often through extended family or friends. Lupe was able to use the assistance of established family when she first arrived to the US:

Lupe: I had a sister, living there and she had already been living there for a while and she knew the state pretty well.

However, some of the sojourners came to uncharted waters and floated aimlessly until they connected through church or school. During this process, their readiness-at-hand

becomes interrupted, in a temporary form of breakdown. Routine daily life is disrupted while the newcomers attempt to adapt to adjust to an alternative Dasein. Juan had moved to the Midwest after initially settling in a Western state. In spite of his familiarity with life in the US, he was bewildered by moving into a new community until he established contact with a church:

Juan: When I came here I was without a car; I need to buy a car. I didn't know a dealer, I didn't know anybody. The truth is that we have been Christians for a long time, right? So we started to look for a church....” So it ended up that we went one Sunday to the church... and they received us very warmly.

Carmen also found help through a church, and through her child's school:

Carmen: About five or six years ago, I arrived in Midwestern state. I didn't know anybody. Only my husband, my daughter and I, that's it. I wanted to join a church... And so through the church and through the school, we became more familiar with things.

One of the interruptions happens when seeking medical care in their new surroundings, although for a few of the participants the path to medical care had already been cleared by others, as stated by Lourdes:

Lourdes: We had a friend here... she had a son who was the same age as my daughter. So, she helped me find County hospital and to get information about where they gave vaccinations ... So she was a great help to me.

However, for others, integrating into a new medical system proved to be a daunting task. Even though at the time of the interview Marisol had established care with a local Hispanic clinic, she initially had a rough time finding medical care:

Marisol: When I had just arrived from Mexico, and I didn't know how, I thought, how am I going to go to the doctor, shall I say, if I want to be careful to not have babies, How am I going to get pills? Where am I going to go? Or, how? No, I didn't know anything. It had me really worried.

Heidegger says that we wind through the forest along a twisted wood path, confused and lost, until at last we come to a clearing of understanding. The immigrant

arrives to a new and strange place, trying to make sense of a medical system that confuses even the English-speaking patient. The Hispanic immigrant searches for a kind face, a helpful provider who can cross the barrier of language and culture, and clears a path to common understanding. For some, friends and family were present to help guide the way. For Carmen, it was the Hispanic Center Director who provided a stable presence for health care.

Carmen: My daughter got her vaccinations with the Director. For all the vaccinations that my daughter has needed, I ask her if she has them or she's going to give them and she tells me, 'Yes, I'm going to give them to her. Sign me up'.

When the path does not clear, breakdown in the form of malfunction can occur. Let us revisit Linda's trip to the emergency room in terms of breakdown; her experience was so negative that it defined her future use of the medical system:

Linda: Once I went to the hospital, to the emergency room. I told them I had a lot of pain, that I couldn't stand the pain, and could they give me a pill or something so that I could continue to wait, but they said no.... And I said 'it's killing me.' She said, 'Go home and try to calm down.' ... I should have just stayed at my house.

The reaction to malfunction may vary according to the participant. In Linda's case, her reaction was one of avoidance of emergency rooms in the future.

Linda: (In the future I will go to) health clinic for any illness, yes, at health clinic because there, they won't take so long, and they will attend us.

Preserving the family unit - looking toward the future

So, where does the path eventually lead? Is the health of a family unit to be split apart and set adrift because of immigration and health policies? Or does the family have the strength to refreeze the fractures and become an impenetrable fortress to external forces. As part of their journey, participants have privately discussed the future with their

families, questions that immigrant families face, far below the surface and hidden from view. The big question is whether the family has discussed plans to stay in the United States, or to return to their country of origin, either by choice or force. In either case, the families have to decide whether to stay together or to face total breakdown of the family unit and separate.

Liliana Ramos crossed the Mexican/US border as a teenager and lived in the United States until her arrest and deportation in September 2011. At that time the single parent was separated from her three US born children and deported to Tijuana, Mexico. The children had grown up in Oregon and spoke little Spanish; Liliana made the heart-wrenching choice to leave them with relatives to finish school. In an article printed in USA Today, a spokesperson for the Federation for American Immigration Reform (FAIR), Ira Mehlman was quoted as saying “if you are removing the parents from the country...it means that parents made that decision to break up families...They should take their kids with them”. In response to that statement, Rep. Luis Gutierrez, D-Ill stated that parents who take their children equals “defacto deportation of US citizens”. (Welch, 2011).

Stories such as this are now emerging in the media, as the debates over immigration reform heat up. One of the study participants waited until the voice recorder was turned off to reveal that in her home the topic was so intense that the television was switched off whenever “the news” carried a story about immigration policies. Other participants were more forthcoming about their family discussions:

Claudia, who has been in the United States for over twenty years, has no hesitation about her family’s options: “they want to stay here. ‘Well no’, I say to them. ‘When we go, we are all going, you aren’t going to stay.

Everyone together. And when you get older, then you will be able to return.’ ”

Lourdes: “our plan was to be here six years, but then the other children came. So, time has passed, and now we’ve been here for eleven years. If we have to go, we are all going. No one stays here. We don’t like that a family has one here, one there, no! Together in good times or bad.”

Heidegger would likely interpret this dilemma as being ready-at-hand, a reflection of one’s worldview (Heidegger, 1962). Whereas the parent’s understanding of the world arises from the cultural norms of his Hispanic background, the children of Hispanic immigrants have a blended worldview. Their readiness-at-hand is a blend of their Hispanic heritage confounded by influences of growing up in the American society. This difference in worldviews represents conflicts in intergenerational relationships, cracks in the iceberg’s structure, and may not be easily resolved.

Review of Pertinent Literature

Trust as an issue in healthcare

The concept of trust has only recently become scrutinized in healthcare, although it has been addressed in the general literature for many centuries. Author Annette Baier suggests that Plato’s Republic discussed the trust issue:

“[one] expects the majority of citizens to trust the philosopher kings to rule wisely and expects that elite to trust their underlings not to poison their wine..... Where one depends on another’s good will, one is necessarily vulnerable to the limits of that good will. One leaves others an opportunity to harm one when one trusts, and also show’s one’s confidence that they will not take it...”

(Baier, 1986)

People living in modern society may initially trust their government and health care providers to rule wisely in the area of healthcare, and that their best interest is at

heart. However, when those who are given authority fail to protect their “underlings”, a feeling of betrayal that leads to mistrust may develop between the two entities. Minority groups, as vulnerable populations, have endured historical failures in healthcare that have challenged the ability to trust healthcare institutions.

Trust issues in the American culture have a history that dates back to treatment of the Native American by the US government, including desecration of burial grounds and breaking treaties (Satcher, 2006). Mistrust continued in the 20th century as there was a breach of trust when 3000 Native American women were sterilized during 1973-76, having operations without understanding the permanent nature of the procedure (Anonymous, 1977). Native Americans are not the only minority group to take issue with the US government. Trust issues between the African American community and the US government were aggravated by the notorious Tuskegee Syphilis Study, sponsored by Public Health. In 1932 the study recruited four hundred poor, semiliterate African American men in Alabama, who were infected with syphilis and left untreated for forty years. Even though President Clinton formerly apologized for Tuskegee in 1997, deep scars of mistrust in research and healthcare institutions were left in the African American community, perhaps contributing to further disparities from seeking newer treatment (IOM, 2003). Unequal treatment has also been found in the Latino immigrant history. At one time new immigrants were eligible for medical assistance; however during the 1990’s legislation changed their fortune. The Personal Responsibility Work Opportunity Reconciliation act of 1996 (PRWORA) was signed into law by President Clinton in August 1996 (HHS, 2008). The bill was intended to transform the welfare system into a time-limited program, that moved recipients into work and included funding for childcare

and medical coverage. Generally those receiving welfare were given either two or five years to convert to full time work (single parent families were given 30 hour work week), after which time they would be ineligible for cash aid. Another aspect of the law was the child support enforcement to track delinquent parents across state lines and to directly withhold child support from wages. Medical coverage was guaranteed for the health care of poor children. Immigrants were affected by the new law that denied most public assistance to legal immigrants for the first five years or until they became citizens. This policy reversal has caused a widespread mistrust of government sponsored health programs in the Latino immigrant community (Ku, 2007).

Summary

The lived experiences of Hispanic immigrants seeking vaccinations for their foreign-born children proved to be the tip of the iceberg regarding health concerns. Beneath the surface of the seemingly innocuous vaccination process, loom health issues that involve the entire family, as well as the family's future. The overarching finding revealed in this study was the role of trust that Hispanic immigrants used as a guiding barometer for their interactions with the United States health system. While trust served as a major factor in the immigrant health care experience, there were four subthemes.

Subthemes that emerged under the umbrella of trust were health literacy, health disparities, finding a medical home, and preserving the family unit. The subthemes provided a framework to examine the immigrant journey from arrival to the United States, settling into a community, and projection into the family's future.

For the Hispanic immigrant, trust is the primary element that leads healthcare decision making. The initial impact of trust is witnessed with regard to vaccinations, evidenced by the immigrants' knowledge and respect for this health intervention. The myth that immigrants have low health literacy regarding vaccinations is dispelled by consistent findings in the basic understanding of vaccinations, regardless of level of formal education. All interviewed participants displayed belief and trust in the purpose of vaccinations for illness prevention.

Health disparities took on a new form from the traditional disparity profile. In the study, disparities *within* the family led to parental angst; US born children were entitled to health care coverage, foreign-born children were not. Foreign-born children were allotted emergency services, but were denied routine and preventive programs such as Medicaid.

In addition to care for their children, parents needed to find a medical home for themselves, and often turned to friends and churches for guidance, to find a trusted provider. In securing a medical provider, trust was an important factor, not the trust in efficiency or technology, but the trust in a provider's ability to treat patients with kindness and respect, all important elements in the Hispanic culture.

Finally, as Hispanic immigrants discussed the future, the preservation of a healthy family unit emerged as a consistent subtheme. In the current political climate of uncertainty regarding immigration, most of the study participants acknowledged they had discussed this topic with their children. Due to a general lack of trust in the political system, and in preparation for the future, they discussed that if returning to their country of origin became necessary, whether the entire family would return, or if children would

stay in the United States. Here is where a division occurred; given a choice, parents wanted the entire family to stay as a unit, while children desired to stay in US, even if it meant separation from family members. In some cases the sentiments were so strong that parents continued to sacrifice their wishes of returning to original country in order to keep the family together, while others prohibited children from watching the news and simply tabled the discussion. As changes in immigration take a more prominent position in the public eye, struggles that lie beneath may become more visible.

CHAPTER FIVE

Discussion and Implications

This section contains the results of the data analysis, the specific aims, the hermeneutic process, implications for future nursing practice, recommendations for research, and limitations of the study.

Data Analysis

Trust

Trust is a universal phenomenon that transcends human history. Long before the existence of the American continents was known, groups of immigrants placed blind trust in a brighter future and moved to new lands. For example, Hebrew slaves in Egypt followed Moses to the “Promised Land”, immigrants from surrounding Mediterranean and northern African countries flocked to ancient Rome seeking work (Noy, 2000), and our founding fathers crossed the Atlantic Ocean seeking religious freedom. So, although the phenomenon of trust is not unique to modern day Hispanic immigrants, it is the key to “finding their way” in the United States. Self-reliance provides the foundation for having the strength to endure new situations, and to persevere in finding health providers who reflect their cultural values to ensure well-being.

In 2012 the Centers for Medicare and Medicaid Services (CMS) released new criteria for hospital reimbursement, based on patient satisfaction scores. The National Research Corporation in conjunction with private survey companies has developed patient satisfaction tools to assist patients report their experiences. For example, within

the forty five questions sent to patient homes by the Picker institute were questions such as:

“During this hospital stay, how often did nurses treat you with courtesy and respect?”

“During this hospital stay, how often did nurses explain things in a way you could understand?” (Catalyst, 2012).

The questionnaire has also been made available in Spanish. As we know from this study data, one of the participants used a hospital questionnaire to voice her complaints about poor provider care, based on experiences while seeking care for her nine year old son. As the Hispanic population in the US continues to grow, the Hispanic culture’s value of trust may become a criteria for healthcare performance issues in the mainstream.

Health literacy

As seen in this study, health literacy among immigrants has been misportrayed by the media. Recent studies in immigrant populations have proposed the concept of the Healthy Immigrant phenomena, whereby persons immigrating into the United States initially enjoy a higher rate of health than do natives. The health factors include wellness, lack of disease, and less dependence on medical establishments for health concerns. Health literacy plays a large part of the immigrant’s awareness of vaccination benefits and keeping up to date on shots. We perceive that knowledge about the role of vaccinations in preventing disease is part of the healthy immigrant phenomena. An interesting question is whether children of immigrants will continue to share their parents’ perspective, or if they will become influenced by a larger community to the growing sentiment of vaccination distrust.

Health disparities

Healthy People 2020 addresses the need to narrow the gap in health care disparities. In the case of Hispanic immigrants, we have seen that disparities occur both in the community at large, and within the family structure. While health care reform is a major focus in Washington political debates, the disparities experienced within immigrant families with both foreign born and United States born children are scarcely addressed. This problem is not unique to Hispanics; all immigrants fall prey to inconsistencies in health practices across the country. For example, although twenty two states have embraced SCHIP for a new immigrant to receive healthcare within the first five years of residency, Midwestern states are not among them. States that embrace SCHIP benefits help erase disparities within Hispanic immigrant families. Immigration reform is a current hot topic in Washington, but does not appear to address health disparities for immigrants.

Medical home

When the Hispanic immigrants first arrived, one of the main problems they encountered was to find adequate health care. Healthy People 2020 also addresses the need for a medical home. According to the Agency for Healthcare Research and Quality, a medical home should provide comprehensive care, be patient centered, coordinate care, and provide accessible services, quality and safety. This definition of a medical home reflects desires expressed by interviewed immigrants, who in some cases eventually found a satisfactory medical home, but only after a long bumpy journey.

Preserving the family unit

An unclear but present danger facing some immigrant families is whether to stay in the US and trust the political system, or else take the entire family back to their country of origin. The dilemma they face is that their children have established firm roots in the United States, and have little desire to start over in a Spanish speaking country. Uprooting the family would defeat the purpose of immigrating in the first place. One fear is that splitting up the family unit may come by force rather than by choice.

On the political front, separation of families by deportation has come under debate. In the 2011 Republican primary debates, Former House Speaker Newt Gingrich was quoted as saying:

If you've come here recently, you have no ties to this country, you ought to go home, period...If you've been here 25 years and you got three kids and two grandkids, you've been paying taxes and obeying the law, you belong to a local church, I don't think we're going to separate you from your family, uproot you forcefully, and kick you out. (Goodenough, 2011)

In contrast, as a presidential candidate, Governor Mitt Romney responded:

To say that we're going to say to the people who have come here illegally that now you're all going to stay...will only encourage more people to do the same thing. (Goodenough, 2011)

The view of his opponent, President Barack Obama was highlighted in his Comprehensive Immigration reform speech on immigration at the American University School of International Service, July 2010:

Now, if the majority of Americans are skeptical of a blanket amnesty, they are also skeptical that it is possible to round up and deport 11 million people... immigrants who are here illegally are now intricately woven into that fabric. Many have children who are American citizens. Some are children themselves, brought here by their parents at a very young age, growing up as American kids, only to discover their illegal status when they apply for college or a job... So even if it was possible, a program of

mass deportations would disrupt our economy and communities in ways that most Americans would find intolerable. (Washington Wire, 2010)

With all the political upheaval surrounding this issue, in whom can the immigrant trust?

At this time there is no clear answer, but immigration reform is a top priority in the current administration.

Revisiting the Specific Aims

The results of the data analysis gave insight into the aim of the study, and provided additional information beyond the original intent.

Aim 1: Describe the lived experience of Latino immigrants in obtaining vaccinations for their foreign-born children. Each participant addressed experiences related to the process of obtaining vaccinations for his foreign-born children. Participants had both positive and negative experiences. In some cases vaccination records from other countries were accepted as meeting United States requirements, while in other cases children were revaccinated in spite of documentation showing the vaccines had been obtained outside the United States. Participants with both foreign and US born children commented on healthcare disparities within the nuclear family.

The Hermeneutic Process

The use of Phenomenology allows the researcher to reveal concealed thoughts that lie beneath the surface, thoughts of importance to the Hispanic lived experience. The goal of the hermeneutic process is to understand the worldview of study participants, and factors such as health issues, that affect everyday life. Life itself is constantly evolving, and perspective is influenced both by personal history and the context of time and place.

Context plays a major role in one's reality, and this study is witness to generational differences between Hispanic parents and their children; even though they are in the same family, the individual readiness-at-hand varies due to differences in the trifold of past, present and future experiences.

Implications for Nursing Practice

The implications for practice are grouped into three areas: vaccination practices, cultural competency and health policy. The implications for vaccination practices are: acceptance of vaccination records from other countries, consistency in nursing practice for catch-up vaccinations, consistent use of CDC and global guidelines, and improving vaccination tracking processes. These issues were addressed in part by the World Health Assembly Resolution in the document *Global Vaccine Action Plan 2011-2020* (World Health Organization, 2013), a collaborative process of the Vaccine Decade program proposed in May 2012 by a team of experts representing such global organizations as United Nations Children's Fund, World Health Organization and the Bill and Melinda Gates Foundation. The plan addresses six main goals, among which are vaccine standardization to assure universal product quality, and data monitoring of programs regarding immunization coverage. This type of global support should affect nursing practice in a positive manner by increasing trust in vaccinations obtained overseas, and reducing vaccination repetition for immigrants who carry vaccine documents.

On a more local level, new trends in tracking include participation in vaccination programs such as the Indiana Immunization Coalition and recording vaccinations in a state or national registry. This practice is beneficial to nurses for tracking purposes and for obtaining the latest information on vaccinations.

Cultural competency implications include understanding nuances of what it is to be an Hispanic immigrant, the impact of *simpatico* and establishing trust, and the consistent use of trained interpreters. Some nursing programs offer language courses specific to the health care provider. Cultural competence is built into the course text Salud created by University of North Carolina at Chapel Hill, emphasizes establishing a climate of trust with the Hispanic patient (Lunsford, 2012).

Health policy implications place emphasis on education on current issues affecting immigrant populations, and nurses serving as advocates. Nurses can better serve the immigrant population by staying educated on current health policies and issues that affect the group. Specifically, nurses should be aware of health disparities that occur within the nuclear family secondary to immigrant status, and can best serve the family by treating all members equally.

Nurses can become advocates of health reform in the role of educating policymakers on the problem of health disparities. Current health policies affect the ability of a family to find a medical home. Nurses can assist patients to find optimal healthcare resources in the community.

Recommendations for Further Research

There are inconsistencies in current practice in the acceptance of foreign vaccination documents. I recommend research to explore best practices, and to offer guidelines for determining how documents should be processed. The purpose of creating guidelines would be to streamline provider practice and revise practices to best serve patients.

Another recommendation for research is to engage focus groups to discuss the results of this study, and to work toward solutions for issues such as medical home for new immigrants in the community.

A third study recommendation is to compare the perspectives of Hispanic immigrant children and their US-born siblings in order to gain insight into their experiences with vaccinations and other healthcare issues.

Finally, I would expand the current study to other immigrant populations to compare similarities and differences in experiences. This study supports the Healthy People 2020 goal to “achieve health equity, eliminate disparities, and improve the health of all groups” (Healthy People 2020, 2012).

Limitations

One limitation to this study is access to participants. Recruitment was achieved through two sites; this limited participation to Hispanic immigrants who frequented the two sites. A second limitation is the possibility of homogeneity with respect to the church site. Although participants had varied backgrounds, they may have similar interests, especially concerning spiritually based concepts.

A third limitation was time constraints placed at the health clinic site. Clinics were typically held on Mondays or Fridays, therefore participants were selected from those attending clinic on the two days. Although information obtained was rich and informative, there might have been data that was missed by potential participants visiting the site on non-clinic days.

Even with these limitations, the Hispanic population was diversely represented by geographic origin, age and gender. There were participants from Mexico, Central and South America, and both genders had representation. Ages of the parents ranged from mid 20s to late 40s. Future studies should include interviews from the perspective of the Hispanic immigrant children, both those born abroad and in the United States, to compare their thoughts to those of their parents. As policies and other external forces continue to chip away at Hispanic immigrant icebergs, findings from this study will serve as a guide to educate health providers and to understand the complexities of the immigrant experience.

Appendix A

Initial Probes and Study Questions:

Tell me about a time when you needed to find vaccinations for your child.

How is it that vaccinations affect your health?

Tell me about vaccinations in your home country.

How is it that vaccinations are or are not beneficial?

Demographics:

Country of origin

Gender of the parent

Ages of the children

How long has the family been living in the US?

Appendix B

Amended Probes and Study Questions:

Tell me about a time when you needed to find vaccinations for your child.

How is it that vaccinations affect your health?

Tell me about vaccinations in your home country.

How is it that vaccinations are or are not beneficial?

Tell me about a good experience with the health care services.

Tell me about a time you were frustrated with health care services.

Do you have a usual place to visit for health concerns?

How did you find out about the place for health care?

Has there been someone who helped you a lot?

If you could change one aspect of your experience to make it better for others, what would you change?

What can nurses do to improve your experience?

Appendix C

Demographic Table

PARTICIPANT	1	2	3	4	5	6	7	8	9	10	11	Total
ORIGIN												
Mexico		x	x	x	x		x	x		x	x	9
Central America	x					x						1
South America									x			1
GENDER												
Male						x		x				2
Female	x	x	x	x	x		x		x	x	x	9
AGES OF FOREIGN-BORN CHILDREN*	7mo	3y	2mo 4y 5y	18mo	12y	3y	4y	8y 12y	5y	1y+	3y 5y	
US-BORN CHILDREN**	1	1	0	1	2	0	0	1	2	3	1	
HOW LONG IN US ***	8	8	6	11	11	8	10	12	10	16	12	

*Ages of children upon arriving to US (mo=months, y=years) +child was left behind in country of origin

**Number of children born in United States after family resettled

***How many years immigrant family has been in the United States

Appendix D

Bi-national Immunization Table

Revised January 2013

2013 Binational Immunization Resource Tool for Children from Birth Through 18 Years

Vaccine doses administered in Mexico may be counted as valid in the United States (including vaccines not licensed for use in the U.S.) if the dose or doses are documented in writing (including the date of administration) and comply with the minimum intervals and minimum ages as recommended by the Advisory Committee on Immunization Practices. See <http://www.cdc.gov/vaccines/schedules/downloads/child/mmrw-child-schedule.pdf>.

MEXICO		Vaccines for Infants and Adolescents		USA	
DOSES RECOMMENDED BY AGE		DISEASES	DOSES RECOMMENDED BY AGE		
	Antihepatitis B at birth, 2, 6 months ¹	Hepatitis B	HepB birth, 2, 6 through 18 months	Comvax 2, 4, 12 through 15 months	Pediarix 2, 4, 6 months
	Pentavalente Acelular ⁴ 2, 4, 6, 18 months	H. influenzae type b	Hib 2, 4, 6 ³ , 12 through 15 months		Pentacel 2, 4, 6, 15 through 18 months
		Meningococcal (Not offered in Mexico)	MCV4 9 months through 10 years (high-risk) 11 through 12 years, 16 years		HibMenCY 2 through 15 months (high-risk)
Td 12 years	DPT 4 through 6 years	Tos Ferina / Pertussis	DTaP 2, 4, 6, 12 through 18 months, 4 through 6 years	Tdap 11 through 12 years (required in many states for 7th grade entry) ⁵	
	Sabin (OPV) 2 doses per year, from 6 to 59 months of age (in addition to prior 2 doses of IPV)	Difteria / Diphtheria			Pediarix 2, 4, 6 months
	Pentavalente Acelular ⁴ 2, 4, 6, 18 months	Tétanos / Tetanus	IPV 2, 4, 6 through 18 months, 4 through 6 years		Pentacel 2, 4, 6, 15 through 18 months
		Poliomielitis / Polio			Kinrix 4 through 6 years
	Rotateq 2, 4, 6 months	Rotavirus	RotaTeq 2, 4, 6 months or Rotarix 2, 4 months		
	Neumocócica Conjugada (PCV13) 2, 4 months 12 through 15 months	Neumococo / Pneumococcal	PCV13 2, 4, 6, 12 through 15 months	PPSV23 2 through 18 years (high risk)	
	Influenza (yearly) 6 through 59 months, 60 months through 9 years (high risk only)	Influenza	Influenza* (yearly) 6 months or older		
	SR 12 years	Sarampión / Measles	MMR 12 through 15 months, 4 through 6 years	MMRV 12 through 15 months, 4 through 6 years	
	Triple Viral SRP 12 months, 6 years	Rubéola / Rubella			
		Parotiditis / Mumps			
	Varicela 12 months ²	Varicela / Varicella	Varicella 12 through 15 months, 4 through 6 years		
	Antihepatitis A 12, 18 months ¹	Hepatitis A	HepA 12, 18 months		
	HPV 11 years (3 doses) (girls only)	Virus del Papiloma Humano / Human Papillomavirus	HPV 11 through 18 years (3 doses)		
	BCG at birth	Tuberculosis (Not offered in the U.S.)			

Vacunas Combinadas/ Vaccination Combinations

Triple Viral SRP = MMR

Cuddruple = DPT + Hib

⁴Pentavalente Acelular = DTaP + IPV + Hib (August 2007 to present)

⁵Pentavalente = DPT + Hib + HepB (Prior to July 2007)

Vaccination Combinations

Pediarix = DTaP-HepB-IPV

MenHibrix = Hib-MenCY

Comvax = Hib-HepB

ProQuad = MMRV

Pentacel = DTaP-IPV/Hib

Kinrix = DTaP-IPV

FOOTNOTES

* Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting a flu vaccine for the first time or who did not receive a dose containing 2009(H1N1) strain.

** For a listing of Tdap requirements for secondary schools, visit <http://www.immunize.org/tdap.asp>. Some children who were lapsed may have received a dose of Tdap at ages 7 through 10 years.

³ Depending on which Hib vaccine is used, a child may not need the dose at 6 months of age.

FOOTNOTES

¹ For those who have not had the full series by age 12 years, give two doses 1 month apart at 12 years

² Offered to high-risk groups only

See back for immunization tool protocol and translation of common terms

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“The DREAM Act is a bipartisan legislation – pioneered by Sen. Orin Hatch [R-UT] and Sen. Richard Durbin [D-IL] Under the rigorous provisions of the DREAM Act, qualifying undocumented youth would be eligible for a 6 year long conditional path to citizenship that requires completion of a college degree or two years of military service.”

CURRICULUM VITAE

Barbara Sue deRose

EDUCATION

<u>Place</u>	<u>Degree</u>	<u>Date</u>
Indiana University School of Nursing Indianapolis, IN	BSN	1978
Indiana University School of Nursing Family Nurse Practitioner Indianapolis, IN	MSN	2006
Indiana University Doctor of Philosophy Indianapolis, IN	PhD	2013

ACADEMIC APPOINTMENTS

<u>School/Location</u>	<u>Appointment</u>	<u>Date</u>
Indiana University School of Nursing Indianapolis, IN	Teaching Assistant	2003-2006

CLINICAL APPOINTMENTS AND CONSULTATIONS

<u>Employer/Location</u> <u>Date</u>	<u>Position</u>	
IU Health, Inc Indianapolis, IN	Nurse Practitioner Lifecare Clinic	2007-present
Take Care Health Clinics Indianapolis, IN	Nurse Practitioner	2007-present
Methodist Hospital Indianapolis, IN	Staff Nurse Cardiovascular Educator	1983-2007
US Embassy Colombo, Sri Lanka	Relief Nurse	1980-1983
Overseas Children's School Colombo, Sri Lanka	School Nurse Teacher	1981-1982
Massachusetts General Hospital Boston, MA	Staff Nurse Cardiovascular Unit	1978-1980

ACCREDITATIONS

NaspeXam Testamur	Specialist in Cardiac Electrophysiology	1999
NaspeXam Testamur	Specialist in Cardiac Device Therapy	2000
American Academy of Nurse Practitioners	Certified Family Nurse Practitioner	2006
Association of Nurses in AIDS Care	Advance Aids Certified Registered Nurse	2010

PROFESSIONAL ORGANIZATIONS

Indiana Society of Pacing and Electrophysiology Past Co-Chair	1994-present
Heart Rhythm Society (formerly NASPE)	1994-present
Sigma Theta Tau International, Alpha Chapter	2006-present
Midwest Nursing Research Society	2008-present
American Academy of Nurse Practitioners	2006-present
Association of Nurses in AIDS Care Current President Central Indiana ANAC National Committees: Diversity, Awards, Global	2008-present

HONORS

HRSA Scholarship Award, Indiana University	2008-2009 2010-2011
William and Doris Rodie Dissertation Scholarship	2011

PRESENTATIONS

<i>Transvenous Implantation of Cardiac Defibrillators</i> Bard Electrophysiology Symposium, Seattle WA	1996
<i>Basic Electrophysiology</i> NASPE International Convention, San Diego CA	1998

PROFESSIONAL SERVICE

American Heart Association Certified CPR and ACLS Instructor	1998-2008
MNRS abstract reviewer	2008-2010
Sigma Theta Tau International – Delegate to US-China forum	2008
Indiana University mission to Calnali, Mexico – nurse services	2004-2005

PUBLICATIONS

deRose, B.S. (2001). Conduction Intervals and Refractory Periods, *EP Lab Digest* November issue.

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